STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the Matter of the Appeal of **Whittier Rehabilitation and Skilled Nursing Center** from a determination to recover Medicaid Program overpayments.	**Decision After Hearing** #19-5602

Before: John Harris Terepka
Administrative Law Judge

By videoconference
September 22, November 9, 2022
Record closed April 3, 2023

Parties:

New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Patrick F. Scully, Esq.
Dionne A. Wheatley, Esq.
Dionne.Wheatley@omig.ny.gov

Whittier Rehabilitation and Skilled Nursing Center
1 Whittier Way
Ghent, New York 12075
By: John F. Darling, Esq.
Bond, Schoeneck & King
350 Linden Oaks, Third Floor
Rochester, New York 14625
JDarling@bsk.com

JURISDICTION

The New York State Department of Health (the Department) acts as the single state agency to supervise the administration of the Medicaid Program in New York State. Public Health Law 201(1)(v); Social Services Law 363-a. The Office of the Medicaid Inspector General (OMIG) is an independent office within the Department, responsible for the Department's duties with respect to the recovery of improperly expended Medicaid funds. PHL 31.

By final audit report dated September 24, 2020, the OMIG determined to recover Medicaid Program overpayments from Whittier Rehabilitation and Skilled Nursing Center (the Appellant). (Exhibit 3.) The Appellant requested this hearing pursuant to SSL 145-a and 18 NYCRR 519.4 to review the overpayment determination. (Exhibit 1.)

HEARING RECORD

OMIG witnesses:	William Kniskern, audit manager
OMIG exhibits:	1-8, 10
Appellant witnesses:	[redacted] consultant Leo Curtin, director of long-term care [redacted] consultant
Appellant exhibits:	Q, R, S, T
ALJ exhibits:	ALJ I (January 17, 2023 letter with attachments)

A transcript of the proceedings was made. (Transcript pages 1-453.) The record remained open until April 3, 2023 for the submission of post hearing briefs.

SUMMARY OF FACTS

1. Whittier Rehabilitation and Skilled Nursing Center is a residential health care facility (RHCF) or nursing home as defined at PHL 2801.2, in Ghent, New York. It has a certified capacity of 120 beds and is enrolled as a provider in the Medicaid Program. (Exhibits 6, 10.)

2. OMIG auditors reviewed the Appellant's reimbursement from the Medicaid Program for the rate period January 1, 2013 through December 31, 2017. The operating portion of the Appellant's Medicaid reimbursement rate during this period was based upon its RHCF-4 cost report for the base period January 1 through December 31, 2007. (Exhibits 5, 10.)

3. The OMIG issued a draft audit report dated November 8, 2019, advising the Appellant of preliminary findings of overpayments attributable to the OMIG's audit determination to eliminate utilization review and inhalation therapy as noncomparable costs in the 2013 through 2017 rates. The draft audit report stated its reasons as:

> … 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. Changes of this nature must be reported by the Provider in accordance with 10 NYCRR 86-2.27. (Exhibit 2.)

4. On December 27, 2019 and February 28, 2020, the Appellant submitted responses to the draft audit report objecting to the audit findings. (Exhibit 8.)

5. On September 24, 2020, after it reviewed the Appellant's responses to the draft audit report, the OMIG issued a final audit report confirming its determination to recover, pursuant to 10 NYCRR 86-2.27, Medicaid Program overpayments in the amount of $2,233,595. This amount represented the reimbursement the Appellant received that was attributable to noncomparable costs for inhalation therapy during the 2013-2017 rate years, and for utilization review during the 2015-2017 rate years. (Exhibit 3.)

6. In 2007, the base year for the Appellant's 2013-17 Medicaid operating rates, the Appellant operated a 20 bed long term ventilator unit and a 100 bed nursing home, which received separate Medicaid per diem reimbursement rates. (Exhibit 8, page 002; Exhibit 10, page 12.)

7. The Appellant's 2007 cost report included costs for inhalation therapy (cost center 035) in the amount of $866,849, and for utilization review (cost center 020) in the amount of $96,291, both reported as noncomparable operating costs. (Exhibit 5, page 001.) The Department of Health's Bureau of Long Term Care Reimbursement (BLTCR) adjusted the inhalation therapy figure to remove $139,162 in property costs. (Exhibit 5, page 001; Exhibit 6, page 007; Exhibit 10, schedule 15 and exhibit h thereto.) It allocated a 20% "traceback" of the remaining $727,687 to the separately reimbursed long term ventilator unit, reducing the nursing home's allowable inhalation therapy cost to $582,150. For utilization review it allocated a 7.5% "traceback," reducing the nursing home's allowable cost to $89,069. The BLTCR then allowed these adjusted amounts of $582,150 for inhalation therapy and $89,069 for utilization review as noncomparable nursing home costs in 2007. These allowed costs were subsequently used to calculate the Appellant's nursing home Medicaid reimbursement rate for the rate years 2013-2017. (Exhibit 4; Exhibit 6, pages 007, 028, 042, 056, 114; Transcript, pages 199-200.)

8. The Appellant closed its 20 bed ventilator unit in 2008 and the Department approved a conversion of the 20 ventilator unit beds to nursing home beds. (Exhibit 8, page 002; Transcript, pages 19, 111-12, 241-42, 267-68.) The existing 100 bed nursing home became a 120 bed facility that was reimbursed at the nursing home rate during the period 2013-17.

9. The Appellant's 2013-2017 cost reports reported no costs in cost center 035 for inhalation therapy. Its 2015-2017 cost reports reported no costs in cost center 020 for utilization review. (Exhibit 4; Exhibit 5, pages 004, 007, 010, 013, 016.)

10. On audit, the OMIG eliminated noncomparable costs attributable to inhalation therapy from the Appellant's reimbursement rate for the 2013-2017 rate years, and eliminated noncomparable costs attributable to utilization review for the 2015-2017 rate years. (Exhibit 3, attachment B; Exhibit 6, pages 079, 086, 100, 107, 121.) The recalculation of the Appellant's reimbursement for these years yielded the audit overpayment amount.

ISSUES

Has the Appellant established that the OMIG's audit determinations to recover Medicaid reimbursement attributable to noncomparable costs for inhalation therapy and utilization review were not correct?

APPLICABLE LAW

A residential health care facility can receive reimbursement from the Medicaid Program for costs that are properly chargeable to necessary patient care. As a general rule, these kinds of costs are allowed if they are actually incurred and the amount is reasonable. 10 NYCRR 86-2.17. Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the Commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item. 10 NYCRR 86-2.17(d).

The facility's costs are reimbursed in the form of a per diem rate established by the Department on the basis of costs reported by the facility. PHL 2808; 10 NYCRR 86-2.10. The per diem rate is the amount the facility may charge per day for a Medicaid covered patient. 10 NYCRR 86-2.10(a)(6). The rate is established prospectively, that is, in advance of the actual "rate period" to which it applies. After the facility has submitted a cost report detailing its actual costs incurred during a designated "base period," the

Department adjusts and uses the reported costs to compute the facility's rate for one or more later rate periods. 10 NYCRR Part 86-2. The base year for operating costs (direct, indirect, and noncomparable costs) applicable in this case is 2007. 10 NYCRR 86-2.40(g),(q)&(w).

The rationale for the prospective method is that it:

> ...creates an incentive to keep costs low by allowing the facility to retain the difference when the predicted rate of reimbursement turns out to be greater than the ultimate actual cost. Wellsville N.H. v. Axelrod, 142 A.D.2d 225, 535 N.Y.S.2d 257 (1988); *lv. to appeal den.* 74 N.Y.2d 602, 541 N.Y.S.2d 985 (1989).

The operating portion of a facility's reimbursement rate includes three components – direct, indirect, and noncomparable. PHL 2808(2-c)(a); 10 NYCRR 86-2.10(a)(7). The direct and indirect components reflect a "statewide price component" that considers the reported costs of both the individual facility and of "peer group" facilities. PHL 2808(2-c)(a); 10 NYCRR 86-2.10(c)&(d); 86-2.40(c). The noncomparable component is facility specific, intended to reflect costs which because of their nature are not subject to peer group comparisons. 10 NYCRR 86-2.10(f); 86-2.40(w)&(x). Utilization review (cost center 020 on the cost report), defined at 10 NYCRR 455.20, and inhalation therapy (cost center 035 on the cost report), defined at 10 NYCRR 455.27, are noncomparable costs. 10 NYCRR 86-2.10(f); 86-2.40(x).

Facilities are required to complete and submit an RHCF-4 cost report each year. 10 NYCRR 86-2.2. While rate year cost report figures are not the basis for calculation of an operating rate, which is derived from the base year cost report, there are exceptions to this general methodology. One exception is a requirement that providers notify the Department immediately of the deletion of any previously offered service and its cost impact on the facility. The Department is entitled to recover any rate year overpayments

attributable to a previously offered service that had been deleted in that rate year. 10 NYCRR 86-2.27.

A reimbursement rate is provisional and subject to audit for six years. If an audit identifies errors in the provisional rate, the Department can retroactively adjust the rate. SSL Section 368-c; 10 NYCRR 86-2.7; 18 NYCRR 517.3. The Department may then require the repayment of any amounts not authorized to be paid under the Medicaid Program. 18 NYCRR 518.1. If the Department determines to recover an overpayment, the facility has the right to an administrative hearing. 18 NYCRR 519.4. The facility 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).

Former Department of Social Services (DSS) 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. Also pertinent are Department of Health regulations at 10 NYCRR Part 86-2, which concerns reporting and rate certifications for residential health care facilities; Part 415, which sets forth minimum standards for nursing homes; and Part 455, which defines functional reporting centers.

DISCUSSION

The Appellant objected, in response to the draft audit report, that it was not given an audit closing (exit) conference as is authorized under 18 NYCRR 517.5(a) before the draft audit report was issued. (Exhibit 8, page 6.) This audit was an "in-house post-payment review" with no onsite review of the provider's documentation. A "desk audit" such as this is authorized under 18 NYCRR 517.5(a) and does not require an exit conference be held before the issuance of a draft audit report.

This audit did not, as the Appellant also claims, "disallow or adjust Appellant's reported 2007 costs." (Appellant brief, pages 3, 10-13.) It disallowed reimbursement for them in the rate years. This was not an audit of the 2007 cost report nor was such an audit required. The OMIG did not review or question the accuracy or propriety of the costs reported and allowed in the 2007 base year cost report, nor would it be authorized to do so more than six years after the filing of the report. 18 NYCRR 517.3. This audit was conducted solely to review the reimbursement paid for the 2013-17 rate years, and the findings were based entirely on audit conclusions that in those rate years services had been deleted within the meaning of 10 NYCRR 86-2.27.

The OMIG audit manager, Mr. Kniskern, explained that this "dropped services" desk audit was one of a number of nursing home audits in which the OMIG conducted in-house reviews of cost reports looking for noncomparable costs reported and allowed in the base year for which no cost was reported in the rate year. (Transcript, pages 38-40, 42, 127.) Upon identifying a facility that had a noncomparable cost allowed in its base year but reported a zero dollar amount in the functional reporting center for that cost in the rate year, the OMIG auditors eliminated the cost from the rate for the rate year on the grounds the service had been deleted, or "dropped." (Transcript, page 130, 132.)

The Appellant reported and the nursing home was allowed substantial noncomparable costs for inhalation therapy ($582,150) and utilization review ($89,069) on the 2007 base year cost report. For the rate years under review, it received $2,233,595 in reimbursement attributable to those allowed 2007 noncomparable costs. The desk audit revealed that in 2013-17 it reported no costs in the inhalation therapy cost center (035), and in 2015-17 it reported no costs in the utilization review cost center (020). The

OMIG auditors concluded that the Appellant had deleted these services without notifying the Department as required by 10 NYCRR 86-2.27. (Transcript, pages 24-25.)

The OMIG disallowed the previously allowed noncomparable costs for the 2013-17 rate years and recalculated the reimbursement rate. As a result, the Appellant's per diem noncomparable reimbursement was cut in half, from $33.16 to $16.82 and then $14.32, and the total nursing home rate accordingly dropped about 8 percent, from an average of about $215.78 to about $198.75. This per diem rate reduction resulted in the $2.233 million overpayment. (Exhibit 3, final audit report attachments A, B, pages 005-006; Exhibit 6; Transcript, pages 67-71.)

The OMIG audit determinations rely entirely on the grounds that the Appellant "deleted" or "terminated" utilization review and inhalation therapy services within the meaning of 10 NYCRR 86-2.27. (Transcript, pages 24-25.) This is because the retroactive adjustment of a prospectively determined rate on the basis of actual rate year costs is otherwise inconsistent with the general prospective methodology, which allows providers to retain the difference even if the predicted rate of reimbursement turns out to be greater than the ultimate actual cost of providing a service. Wellsville, *supra.*

If a rate year cost was reduced but the service was still provided, it would not be appropriate nor did the auditors adjust a rate just because those services cost less than anticipated. For example, the Appellant reported $74,912 as utilization review in 2013 and $80,814 in 2014, yet the OMIG appropriately allowed, in the calculation of its 2013 and 2014 rates, the full $89,069 allowed in 2007. (Exhibit 4.)

As described by audit manager Kniskern, the OMIG audit protocol was that a change in the cost reported in a rate year would lead to an audit adjustment "only if it

goes down to zero." (Transcript, page 84.) If any amount at all was reported on the rate year cost report, the audit went no further:

> Q: If the line on that cost report for 2013 had listed ten dollars for utilization review, would it have passed your audit?
>
> A: For 2013, any – anything above zero would – would pass our audit, yes... we didn't make any adjustment for anybody that had any cost in the line. (Transcript, page 105.)

Mr. Kniskern did not deny that there is a difference between a deletion of a service and not having any cost for it. (Transcript, page 143.) This "desk audit," however, did not affirmatively undertake to verify whether the Appellant provided any specific utilization review or inhalation therapy services during the rate years. The OMIG determination that services were deleted was based entirely upon the absence of any reported costs for them in noncomparable cost centers in the rate year cost reports.

The issue, then, is whether the OMIG correctly determined that in 2013-17 there was a deletion within the meaning of Section 86-2.27 of inhalation therapy and utilization review for which the Appellant reported noncomparable costs on the 2007 cost report. The OMIG is entitled to revise these rates only if the services were deleted within the meaning of 10 NYCRR 86-2.27 in those rate years. (Transcript, page 367.)

I. Mandated services. The Appellant argues that the utilization review and inhalation therapy alleged to have been "deleted" within the meaning of 10 NYCRR 86-2.27 are in fact services it was required to provide and so could not and did not "delete." Services are what are required to be provided pursuant to 10 NYCRR Part 415, while 10 NYCRR Part 455 is only about cost centers where costs should be reported. (Transcript, pages 171-76, 194-96.) According to the Appellant, if it continued to provide services as

required by Part 415, it does not matter where rate year costs were reported or in what amount in order to defeat a rate year adjustment for deletion of the services. (Appellant brief, page 13.)

The Appellant claims that utilization review, because it is related to "ongoing evaluation of the quality of care provided," is part of the "Resident Assessment and Care Planning" required under 10 NYCRR 415.11. (Exhibit 8, page 009; Appellant brief, pages 19-20.) Nowhere does 10 NYCRR 415.11 mention 10 NYCRR 455.20 utilization review. The Appellant claims "[a]s to the inhalation therapy services, these too are mandated services to be provided by all skilled nursing facilities when needed by a resident (10 NYCRR 415.12(k))." (Exhibit 8, page 009.) Nowhere does 10 NYCRR 415.12(k), which provides "[t]he facility shall ensure that residents receive proper treatment and care for... respiratory care," mention 10 NYCRR 455.27 inhalation therapy.

The cost center definitions at 10 NYCRR 455.20 & 455.27 clearly describe specific services, not "minimum operating standards" as are set forth at 10 NYCRR Part 415, which "expresses expectations for facility operation." 10 NYCRR 415.1(a)(3)&4). The cost center defines the service for cost reporting purposes, and the 10 NYCRR 86-2.27 deletion of service regulation is about cost reporting and reimbursement, not Part 415 "Minimum Standards." It will not be concluded that what is reported in the cost center is simply irrelevant to the issue of deletion of a service within the meaning of 10 NYCRR 86-2.27. It is rational for the Department to evaluate the provision of a service under this Part 86-2 reimbursement regulation in relation to the question whether any

reimbursable cost is associated with it, and it is rational to conclude that for reimbursement purposes, provision of a service does mean incurring a cost.

Case law provides support for this view:

> This Court holds and determines that the respondents' interpretation of "deletion of service" based upon whether petitioner incurred any cost for such service is wholly rational and reasonable. Northern Metropolitan RHCF v. Novello, 4 Misc3d 394, 777 N.Y.S.2d 277 (2004).

In affirming this decision, the Appellate Division wrote:

> Although petitioner contends that this arrangement did not constitute a "deletion" of services because its ADHC patients continued to actually receive transportation service, we find DOH's interpretation of its own regulation to be more persuasive... DOH's view that a service is "deleted" when the provider ceases to be financially responsible for same is consistent with the regulation's explicit reference to "the cost-impact" of such deletion upon the provider. Moreover, such interpretation appears consistent with prior DSS precedent on this issue. Accordingly, under the circumstances, we cannot conclude that the construction afforded by DOH is irrational or unreasonable and its determination must therefore be sustained. Northern Metropolitan RHCF v. Novello, 24 A.D.3d 1069, 806 N.Y.S.2d 291 (3rd Dept. 2005).

See also Wells Nursing Home v. Novello, 55 A.D.3d 1202, 866 N.Y.S.2d 806 (3rd Dept. 2008).

The Appellant seeks to distinguish these cases on the grounds that they involved services that could be and were provided and billed to Medicaid by third party providers. (Appellant brief, pages 14-17.) In Northern Metropolitan the provider was initially approved for reimbursement to provide transportation, but subsequently and instead contracted with outside providers who billed Medicaid directly. Mr. ████ pointed out lab and x-ray services, which were at issue in Wells Nursing Home, as other examples of ancillary services that a nursing home can provide and include in its costs, that can also be discontinued, "unbundled" from the rate, and then billed directly to Medicaid by third parties. (Transcript, pages 165-68, 176-77, 195-96.) The OMIG did not dispute Mr.

█████s assertion that "at least as far as I know" a third party cannot bill Medicaid for utilization review or inhalation therapy. (Transcript, pages 169-170, 192-93; Appellant brief, page 17.)

According to the Appellant:

> In each of the two cases, the fact that no costs were reported was a relevant, but not the deciding, factor in the upholding of the recoupments. What was deciding in those cases was the provision of the service by third parties with separate, and duplicate, reimbursement for those services. (Appellant brief, page 22.)

This attempt to reduce the absence of costs to a "relevant, but not the deciding, factor" and replace it with "provision of service by third parties with separate, and duplicate, reimbursement" does not reflect the language of the decisions, neither of which clearly expresses such a view, or any language in 10 NYCRR 86-2.27. The Appellant's argument that the reasoning in Northern Metropolitan and Wells is inapplicable to services that are not directly billed to Medicaid by third parties, is not persuasive.

II. Costs incurred. The Appellant argues that even if no longer having any cost for a service does constitute deletion of the service for reimbursement purposes, it did not delete these services because costs for providing the services were incurred, just reported elsewhere. (Transcript, page 366.) Providers are required to classify expenses in accordance with the definitions of functional cost centers set forth in 10 NYCRR Part 455. 10 NYCRR 454.2(b)(4). If the Appellant claims to have had utilization review or inhalation therapy costs in the rate years, it was required to report them accurately and properly in the appropriate functional cost centers. It failed to do so and reported instead that it had no such costs.

Contrary to claims in its brief (Appellant brief, pages 17-18), the Appellant has had an opportunity, in response to the draft audit report and again at this hearing, to "correct" any errors in its 2013-17 cost reports by showing the provision and cost of these services. It complains that because it was not given an onsite audit and an exit conference it did not have the opportunity to correct the rate year cost reports or produce records to show costs were in fact incurred and reported elsewhere. (Appellant brief, pages 17-18.) If it is now the Appellant's position that it did have identifiable, documented costs properly reportable in these noncomparable cost centers in the rate years, it has not been prevented from bringing that documentation forward to substantiate them during this audit in a response to the draft audit report, and again at this hearing. The Appellant was specifically advised in the audit report that the OMIG considered its failure to document services were provided and actual costs were incurred to be pertinent. (Exhibit 3, page 14.) Its argument that "the Appellant could not provide the documentary evidence and legal bases establishing that the services were not terminated until this hearing" (Appellant brief, page 18) is an admission that it has now had an opportunity to address the issue and show the provision and cost of these services.

The Appellant offered little explanation for the complete disappearance from its 2013-17 cost reports of $670 thousand reported in 2007 in noncomparable cost centers specifically designated for reporting the cost of those services. Its witness [redacted] asked how these reported 2007 costs could so quickly go to zero, answered: "I don't know.... I would say there may be misreported costs, I – I don't know. That's what the – the other witnesses will testify to affirm... unless they're misreported, I – yeah, I can't explain that." (Transcript, pages 186, 203-204.)

The Appellant's two other witnesses did not explain it. Regarding the complete disappearance from the rate year cost reports of $89 thousand in utilization review costs reported and allowed on the 2007 report, director of long-term care Leo Curtin claimed there were costs but testified: "How it was reported I can't speak to." (Transcript, pages 265, 287.) Regarding the complete disappearance of $582 thousand in inhalation therapy costs, Mr. Curtin testified that the actual services provided to patients in the rate years 2013-17 did not change "at all," but then immediately went on to also say:

> Q. What changed was in 2007 you had the ventilation therapy, thereafter you were not providing ventilation therapy, correct?
> A. That's correct. (Transcript, page 269.)

Appellant witness [redacted] was the accountant who oversaw preparation of the Appellant's cost reports for 2007 as well as 2013-16. (Transcript, pages 309, 331-32, 334.) She said that after 2014 costs for utilization review "were put into other cost centers, nursing admin and administration." (Transcript, pages 334-36, 410.) For inhalation therapy, she said:

> That the -- the services that they provided had come down to almost nothing and instead of using the cost center for inhalation therapy, they chose to use the cost center for central supply on -- and that would be for the supply type items and the purchase contracted. And all of the nursing costs to provide those services is in line zero five one. (Transcript, page 393.)

She conceded, however, that she did not know if the Appellant continued to provide inhalation therapy services during the rate years. (Transcript, page 342.) She also agreed that not all respiratory costs belong in inhalation therapy, and that respiratory care belonged in nursing cost center 051. (Transcript, pages 358-59, 361.)

Having itself reported no costs for utilization review or inhalation therapy in the rate years, the Appellant has also failed to identify and substantiate "misreported" rate

year costs that belong in the utilization review or inhalation therapy cost centers. It claims that its noncomparable costs for these services were "most likely" staff salaries that were reported in the nursing facility or administration cost centers. (Appellant brief, pages 23, 28.) No time studies as required by 10 NYCRR 454.2(c) were offered to substantiate a basis for allocating any staff salaries from those direct cost centers to noncomparable cost centers. Instead, the Appellant simply claims that "[i]t would appear that there was a cost reporting error." (Appellant brief, pages 23, 28.) Because some services must have been provided, some costs must have been incurred and reported elsewhere: "Either by error or by – by misreporting. I don't know." (Transcript, page 378.) The Appellant is unable to identify why or where the alleged error was made. This failure to accurately trace and substantiate costs ignores very specific functional reporting requirements set forth at 10 NYCRR 454.2, and recordkeeping requirements applicable to all Medicaid Providers. 18 NYCRR 504.3(a).

III. Provision of services. The Appellant did not show how any of the costs for services reported in 2007 were incurred in the rate years or where they could be found in the 2013-17 cost reports. Instead of bringing forward and proving rate year costs, the Appellant's answer to its own question "Where Are [utilization review and inhalation therapy] Costs Reported on the RHCF-4s for the Rate Years?" is, for both cost centers: "While the question is interesting, its answer is not easily provided as the hearing record shows." Failing to identify any such costs, it then returns to the argument that an answer is not relevant because "that fact that zero costs were reported is not dispositive."

(Appellant brief, pages 22, 28.) All that matters is that something like the services in question must have been provided if they were needed.

Inhalation therapy: The Appellant's documentation fails to demonstrate the provision of this particular 10 NYCRR 455.27 service, as distinguished from the general respiratory care the Appellant relies on to justify it. It offered facility records purporting to show that during the rate years it did provide respiratory care pursuant to its obligation under 10 NYCRR 415.12(k). Minimum Data Set (MDS) reports showed the types of services provided to residents included some respiratory services, and clinical and treatment records for four residents documented the administration of oxygen and albuterol during the audit period. (Exhibits Q, R, S, T.)

10 NYCRR 455.27 is very specific about what counts as an inhalation therapy service and how it is to be measured:

> This functional reporting center must contain all the expenses associated with the administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy as prescribed by physicians. This function is performed by specially trained personnel who initiate, monitor and evaluate patient performance, cooperation and ability during testing procedures. Additional activities include but are not limited to the following: assisting physician in performance of emergency care; maintaining open airways, breathing and blood circulation; maintaining aseptic conditions; transporting equipment to patients' bedsides; observing and instructing patients during therapy; visiting all assigned patients to ensure that physicians' orders are being carried out; inspecting and testing equipment; enforcing safety rules; and calculating test results. 10 NYCRR 455.27.

The regulation goes on to specify that the standard unit of measure is the number of treatments, and that "[t]he number of treatments shall be obtained from an actual count maintained by the inhalation therapy department." 10 NYCRR 454.4(a)(2), 455.27(b)&(c). The Appellant offered no evidence or actual count of such treatments.

Instead, it presented records showing oxygen or bronchodilation was given to some patients. (Exhibits S, T.)

Mr. Kniskern pointed out that "not all nursing homes have inhalation therapy." (Transcript, pages 429-30, 432.) The Appellant's own response to the draft audit report stated a nursing home is required to provide inhalation therapy "when needed by a resident." (Exhibit 8, page 009.) Provision of respiratory care required under "minimum operating standards for nursing homes" (10 NYCRR 415.1(a)(3)) does not necessarily constitute or prove the provision of the distinct, and specifically defined service of inhalation therapy.

The Appellant failed to meet its burden of proving that it provided and documented the provision of inhalation therapy as defined at 10 NYCRR 455.27 in the rate years under audit.

Utilization Review: The Appellant produced no documentation for any specific services attributable to utilization review. It instead presented MDS forms and argued: "Accurate and properly completed MDS forms create the basic data for individual case review by the facility." (Exhibit R; Appellant brief, page 20.) Facilities are required by 10 NYCRR 86-2.37 & 415.11 to complete MDS reports. Pointing out that the facility can and should use the MDS assessments in its performance of utilization review does not necessarily mean preparation of those assessments is utilization review. (Appellant brief, pages 19-21.)

MDS reporting requires facilities to conduct an "assessment of each resident's functional capacity." 10 NYCRR 415.11; 42 CFR 483.20. Utilization review is defined to include:

> conducting ongoing evaluation of the quality of care provided. This includes periodic review of utilization of bed facilities and of the diagnostic, nursing and therapeutic resources of the residential health care facility with respect to availability of these resources to all patients according to their medical needs, and recognition of the medical practitioner's responsibility for the costs of health care... The review committee should include two or more physicians with participation of other professional personnel, or a group outside the facility which is similarly composed and which is established by the local medical society and some or all of the residential health care facilities in the locality, or a group established and organized in a manner approved by the Department of Health that is capable of performing such function. 10 NYCRR 455.20.

The standard unit of measure for utilization review as a noncomparable cost is: "The total number of patient cases reviewed by the Utilization Review Committee... The number shall be determined from an actual count maintained in the Utilization Review Committee." 10 NYCRR 454.4(a), 455.20(a)&(b). No utilization review committee was identified by the Appellant nor were any case reviews or count thereof documented.

MDS and utilization review functions may be interrelated but that does not make MDS patient assessment and utilization review evaluation of facility resources interchangeable for cost reporting purposes. The preparation of the MDS is not required only or even primarily for the purpose of utilization review. For example, as the Appellant points out: "Appropriate classification of resident needs and resource utilization through the MDS process is the very foundation of the RUGS system" (Appellant brief, page 21), which is used to calculate a "case mix adjustment" to a facility's Medicaid reimbursement rate. 10 NYCRR 86-2.40(m). The Appellate Division, Third Department, discussing an attempted reclassification of MDS and admissions coordinators' salaries to utilization review, has rejected the idea that these cost centers are interchangeable, noting: "a review of the descriptions of the relevant cost centers supports the Department's further conclusion that petitioner's reclassifications

were not justified." Odd Fellow & Rebekah R&HCC v. Commissioner of Health, 107 A.D. 3d 1095, 966 N.Y.S.2d 587 (3rd Dept. 2013).

Instead of producing documentation that it performed utilization review, the Appellant relies upon the claim that it must have performed it because it had an obligation to do so. This does not mean the Appellant is necessarily entitled to reimbursement of utilization review in the noncomparable component of its rate. When asked "do any facilities not offer utilization review," OMIG auditor Kniskern pointed out that "some do not get a separate amount for utilization review because it's included in their nursing administration." (Transcript, pages 127-28.) Case law and previous hearing decisions have held that a facility is not necessarily entitled to reimbursement for utilization review in the noncomparable component of its rate. Odd Fellow & Rebekah (3rd Dept. 2013), *supra*; Atlantis Rehab & RHCF (#14-4064, DOH hearing decision issued 9/24/21); Nesconset Center for N&R (#15-4992, DOH hearing decision issued 12/01/21).

IV. Rate setting judgment. According to the Appellant, the closure of its vent unit and adding of its 20 beds to the nursing home after 2007, and a sale of the facility in 2017, gave rise to rate determinations by the Department that preclude these OMIG audit adjustments. (Appellant brief, pages 29-32.) It presented no persuasive evidence of any such rate setting determinations.

The Appellant claims the determinations were made at the time the sale was reviewed by the Department's Public Health and Health Planning Council (PHHPC) because the Department had a concern to "keep the Facility open and viable given the

need for residential LTC within Columbia County." According to the Appellant, "DOH worked with Appellant from 2008 through 2017 to ensure that the facility's rates were not out of balance given the elimination of the Vent beds and conversion to NF." (Appellant brief, pages 29-30.)

The 2016 PHHPC documents relied upon the Appellant fail to even mention the vent unit that had closed years earlier, in 2008. (Exhibit 8, pages 010-026.) The concern expressed in those documents was not with "rebalancing" the Appellant's rates in order to keep it open after the vent unit closed. The concern was about "rebalancing" the nursing home bed supply due to underutilization of beds in the region and the "near or below the county level" occupancy of the Appellant's beds in particular, which suggested the conclusion that "not all 120 beds at Whittier seem to be necessary." (Exhibit 8, page 014.) There is no suggestion anywhere in the PHHPC report of a Department determination or even concern to ensure a continuation of any particular component of Whittier's allowable costs or reimbursement rate. (Exhibit 8, pages 010-26.)

The Appellant nevertheless suggests that because the direct component of its nursing home rate was lower in comparison with other nearby Columbia County facilities, the Department must have made some special determination to boost its rate. It points out that in comparison with these other facilities, its 2017 per diem operating rate had a roughly $20 higher noncomparable component, which could be attributed to the inhalation therapy cost, and a roughly $20 lower direct component. (Exhibit 8, page 004; Appellant brief, page 31.) The Appellant has not offered any persuasive evidence to document any "rate setting methodology" judgmental determination by the Department intended to recognize and compensate for this alleged disparity.

Wells Nursing Home, *supra*, rejected an argument that the Department has an obligation to ensure some sort of "balance" by providing reimbursement for costs no longer incurred:

> [P]etitioner asserts that the Department acted arbitrarily by focusing narrowly on the subject ancillary services and not considering the full impact of other costs incurred after the base year... While petitioner undoubtedly faced escalating costs in other areas, it nevertheless was not arbitrary for the Department to refuse to permit those newly escalating costs to be partially covered by reimbursement for services not only longer offered by petitioner, but that were provided and billed by other health care facilities... Moreover, the Department is not obligated to continue to reimburse petitioner for services no longer provided simply because petitioner had previously been certified as an efficiently and economically operated facility. *Id.* at 1204-05.

There is no evidence of any intention or determination by the Department to do so in this case.

The Appellant invokes the term "blended rate" in its effort to claim this audit adjustment is "in opposition to the DOH policy" expressed in connection with the 2008 vent bed conversion and/or 2017 sale approval. (Appellant brief, page 29.) A "blended rate" as referred to in the regulations is a blend of statewide and facility specific costs used to determine the direct and indirect, but not noncomparable component of an operating rate. 10 NYCRR 86-2.40(d),(n)&(w). The Appellant did not explain how the noncomparable component of a rate is in any sense "blended." A "blended rate" is not some combination of rate components or of rates that may have been issued for separately reimbursed units in one facility. There is no indication of any special determination to create such a "blended rate" to improve the Appellant's reimbursement after the vent unit closed and its 20 beds were "folded into" the nursing home. The Appellant continued to receive its nursing home rate based on the costs allocated in the

2007 cost report, not some new and special "blended rate" devised solely to "enhance" the nursing home's reimbursement.

There is also no evidence that the Department made any rate setting judgment intended to address some "disparity caused by the previous traceback, and the need for the rate relief DOH provided" or that it "adjusted the traceback to enhance the SNF rate through the non-comparable component." (Appellant brief, page 31.) The Appellant was reimbursed during the rate years on the basis of costs allocated between the nursing home and vent unit by the "traceback" determined in 2007. It is those nursing home costs, allocated in accordance with the original 2007 "traceback," that have been disallowed in this audit and that the Appellant claims should continue to be allowed. (Exhibit 4; Exhibit 6, pages 007, 028, 042, 056, 114; Transcript, page 201.) There is no evidence to support the Appellant's claim that the Department "adjusted the traceback" to in some way address a need for "rate relief" when the vent unit closed or at any time thereafter.

IV. Conclusion. The Appellant has failed to meet its burden of proving the OMIG determination that noncomparable services were deleted in the rate years was incorrect. Insofar as it provided respiratory care or resident assessment and care planning, these services were not shown to constitute inhalation therapy or utilization review. Inhalation therapy may be a form of respiratory care, but respiratory care does not necessarily mean inhalation therapy. Utilization review may consider assessments of resident functional capacity, but those assessments are not the utilization review.

The Appellant failed to document what if any portion of services it did provide, the cost of which it did not allocate and report as inhalation therapy or utilization review, were in fact those services and that it incurred costs for providing them. Consequently, it has failed to prove inhalation therapy or utilization review services that are distinguishable from respiratory care and resident assessment and care planning, the cost of which was "reimbursed to [the facility] under its overall Medicaid rate for inpatients." (Northern Metropolitan, *supra*.) The OMIG could reasonably conclude that these costs were not also reimbursable in the noncomparable component of the rate. They are not the costs for which the Appellant was receiving the noncomparable component of its rate and so they do not refute the Department's conclusion that the services for which the Appellant was receiving reimbursement were deleted within the meaning of 10 NYCRR 86-2.27.

Allowing a facility to "retain the difference when the predicted rate of reimbursement turns out to be greater than the ultimate actual cost" (Wellsville, *supra*) is not the same thing as allowing it to do so when the cost has been completely eliminated. The Appellant offered the example of utilities, suggesting that if "the lights are on," then there is no discontinuance of the service regardless of what appears as utility expense on the cost report. (Appellant brief, page 16.) If, however, the facility on audit is unable to show it any longer incurs any expense to keep the lights on, it is not irrational to conclude that utility service has been deleted as a reimbursable cost. St. Luke's Presbyterian Nursing Center v. Perales, 170 A.D.2nd 915, 566 N.Y.S.2d 968 (1991), upheld a discontinuance of reimbursement for real property tax as an operating cost in the years after the facility obtained an exemption from it.

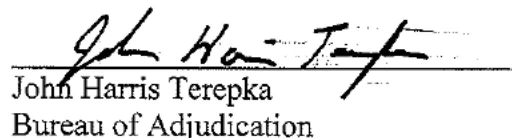
St. Luke's and Wells Nursing Home, *supra,* both recognize that nonrecurring base year costs can properly be allowed as a result of the incentive to operate efficiently where the cost savings are the result of changes related to efficient operation. The Appellant, however, has not demonstrated that it provided inhalation therapy or utilization review at all.

The Appellant argues these services were provided and there were costs that just must have been "misidentified." If that is true, it should be expected to identify either the costs or the services on audit. The Appellant has failed to meet its burden of doing so. If, on inquiry, a facility that has itself reported no cost for a service remains unable to identify any cost and unable to document the provision of the service, it is not irrational or arbitrary for the OMIG to conclude that there was no allowable cost and to determine that the elimination of a cost is the deletion of the service for the purposes of Medicaid reimbursement.

DECISION: The Department's determination to disallow reimbursement for inhalation therapy and utilization review costs is affirmed.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

DATED: Rochester, New York
May 11, 2023



John Harris Terepka
Bureau of Adjudication