February 3, 2023

Rory Howe, Director
Centers for Medicare and Medicaid Services
Center for Medicaid and CHIP Services
State Financial Management Group

Mr. Howe,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) and LeadingAge collectively represent the majority of the nation's Nursing Facilities, Assisted Living, and other critical Medicaid-financed long-term services and supports providers. As LTSS providers, historically our respective membership is, and remains, heavily dependent upon Medicaid funding and, since the pandemic, also upon critical federal stimulus resources to continue to deliver critical services and supports. We appreciate CMS' flexibility and assistance during this ongoing crisis as well as your valuable time for our February meeting.

The purpose of this letter is to provide context and background for our February 9, 2023 call on Patient-Driven Payment Model (PDPM) and Medicaid and Employee Retention Credit (ERC) impacts on Medicaid. First, regarding PDPM, we would like to open a dialogue on the transition from RUG to PDPM.

We appreciate CMS' extensions on the transition and would like to work with the Agency on ensuring successful conversions from RUG to PDPM. Many of our state chapters already are working with states. However, of note, many states are unclear on CMS' timeline for retiring the Optional State Assessment (OSA). Specifically, many believe they must transition to PDPM by October 2023 rather than October 2025. Additional CMS guidance would be helpful to clarify this point. We are concerned states are focused on 2023 and are rushing payment system transitions wh ich could result in compliance challenges with 1902 (a)(30)(A) of the Social Security Act. AHCA/NCAL and LeadingAge would like to be as helpful as possible to CMS and the states on transition. A good first step would be clarification to the states on the timeline and more technical support on the OSA.

Second, we are extremely concerned about anecdotal reports from states regarding treatment of the Employee Retention Credit (ERC). An example of CMS guidance provided to at least one State Medicaid Agency is as follows:

"CMS responded that ERCs are to be treated like any other tax credit. They referred us to the Provider Reimbursement Manual attached, 2122.7.

2122.7 Review of Reasonable Costs, Including Taxes. -- In general, reasonable costs claimed by a provider, including taxes, must be actually incurred. While a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax expense as the reasonable cost actually incurred for Medicare payment purposes. The net tax expense is the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax. Contractors will continue to determine whether taxes and other expenses are allowable based on reasonable cost principles set forth in the Medicare statute and regulations."

Medicare and Medicaid Cost Reports are used extensively to set provider rates, utilizing price-based reimbursement methodologies based on historically reported cost to estimate the cost of providing future services. Applying a one-time source of funding against current cost, thereby reducing future Medicaid rates when ERC is no longer available, would create artificially low rates. And, since Medicaid rates are often determined based on state-wide averages or median cost, providers who did not receive ERC funding, would also be detrimentally impacted. This would be devasting to the NF and ALC sectors (*see Attachment A and discussed further below and Attachment B offers a case example of the impacts on a provider where the state already has begun applying CMS' current guidance*).

ERC Guidance

Respectfully, we believe that ERC funds should be treated as a grant or other revenue for Medicare and Medicaid cost reporting purposes in the period the application is submitted (likely 2020 or 2021) and not offset against cost. The guidance for grant reporting on the Medicare SNF cost report can be found at Provider Reimbursement Manual, Part I, Chapter 6, Section 600.

"*For cost reporting periods beginning on or after October 1, 1983, grants, gifts, and income from endowments, whether or not the donor restricts the use for a specific purpose, are not deducted from a provider's operating costs in computing reimbursable cost. For periods beginning prior to October 1, 1983, restricted grants, gifts, or endowment income designated by a donor for paying specific operating costs were deducted from the particular operating cost or group of costs.*"

The CARES ACT [Public Law 116-136] contained three primary sources of financial assistance for healthcare providers. It is important to note that all three funding sources are intended "*To provide emergency assistance and health care response for individuals, families, and businesses affected by the 2020 coronavirus pandemic.*"

ERC is a source of revenue not dissimilar from the PPP loans or Provider Relief Funds in accordance with published rules and guidelines. All three of these are sources of revenue. However, the ERC is labeled as a tax credit based on the enabling legislation but accessed through

an application process outlined by the Internal Revenue Service [IRS]. And, the primary purpose of the ERC is to give providers additional resources to be used to retain employees during the Public Health Emergency, even though applying for the credit is done via the Employer's Quarterly Tax form 941. Therefore, we do not believe the term, "tax," effectuates ERC treatment as a tax credit.

We would like to discuss ERC treatment as a grant and not offset against cost, analogous to CMS guidance for treatment of PRF and PPP funding. This would mitigate serious issues with Medicaid rate rebasing. If ERC is offset against cost, these one-time funds would lower base rates for all providers, whether they received ERC or not, and would take years for rates to be normalized.

Medicaid Policy, Financing & CMS Policy Priorities

The treatment of ERC also implicates the Medicaid-specific requirements of section 1902(a)(30)(A) of the Social Security Act, which requires that state plans "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

In turn, we believe that a state payment methodology that relies on data from a non-representative base year (e.g., a period in which certain providers received ERCs) is not one that "assure[s] that payments are consistent with efficiency, economy, and quality of care," using Section 30(A) parlance. And the requirements of Section 30(A) certainly control over the likes of nonbinding Medicare guidance issued under outdated cost principles.

Additionally, we highlight that states that are preparing to act to-date appear to be matching state and federal funds for Medicaid NF rates, planning to recoup the dollars from providers and rebudgeting the funds within state budgets. We question whether this is appropriate use of FMAP.

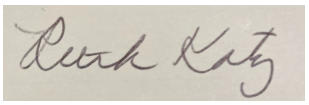
Finally, CMS also is developing a national minimum staffing standard for NFs. Needed new funding for a national standard is estimated to range from $3.7 -- $11 billion per year if implemented. Application of ERC in this manner would severely further exacerbate the funding challenge for a new, federal minimum staffing standard (see Attachment C).

We will send additional materials to inform our February discussion in advance of that meeting. For now, we offer examples of state approaches to ERC treatment for purposes of rates which are helpful – see Attachment D.

In conclusion, we urge CMS to pause guidance to states as well as any possible written guidance until we have a discussion on ERC treatment and state guidance on February 9. We greatly appreciate your valuable time and attention.

Sincerely,

Michael W. Cheek
Senior Vice President, Reimbursement & Market Strategy



Ruth Katz
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CC: Daniel Tsai, CMS Deputy Administrator