Schiavi, Wallace & Rowe, PC

Certified Public Accountants

A newsletter dedicated to long-term care providers.

A New Rate Year is Just Around the Corner

What will this mean for your facility's Medicaid Rates?

By: Judith M. Schiavi, CPA, MBA

Annual Reimbursement Update

On July 1 we will begin a new rate year. Normally that means a higher State budget for the Medicaid program and higher rates for facilities. This July 1 that might not be the case for your building. Why is that? And how can you make an accurate prediction for your budget?

First you need to understand all the variables at play within the new system.

The State Budget

The State has a fixed pool of dollars to allocate to the long term care industry. Each facility must now work hard to retain its rightful share of those dollars. The good news is that the total budget has been increased by 2% on July 1, so there are more dollars to spread around.

Case Mix Volatility

Facilities are learning how to code MDS better, and it shows. In order for the State to continue to pay out the same total dollars, the case mix proportional adjustment (or "CPA" factor) was created. Each July 1 our case mix is reset, and every quarter after that our individual facility case mix is adjusted by a factor of the current quarter's statewide CMI divided by the first quarter's statewide CMI. The following chart summarizes the "case mix creep" since the new system began on January 1, 2015.

Facilities are learning how to code MDS better, and it shows. Check out the "Case Mix Creep" on this table. How does your facility CMI compare?

MI Quarter and Interim Rate Period	Statewide Average MA CMI
QE 09/30/14 (Rates 01/01/15-3/31/15)	1.0216
QE 12/31/14 (Rates 04/01/15-6/30/15)	1.0357
QE 03/31/15 (Rates 07/01/15-9/30/15)	1.0525
QE 06/30/15 (Rates 10/01/15-12/31/15)	1.0700
QE 09/30/15 (Rates 01/01/16-3/31/16)	1.0712
QE 12/31/15 (Rates 04/01/16-6/30/16)	1.0776
QE 03/31/16 (Rates 07/01/16-09/30/16)	1.0839

The "BAF" or Budget Adjustment Factor, effectively applies an across the board decrease to all provider rates so that the total amount projected to be paid equals the total amount the State has allotted for our long term care budget.

Appraisals
Every July 1 the State rolls in the appraisals that were completed within the previous rate year. For Rate Year 2017, the State will be including 48 new appraisals (20 of which are over the ceiling). The remaining appraisals averaged a 15% increase, so we would expect those 28 facilities to receive about a $3/day increase in just the capital component. And since we are dealing with a fixed total budget amount, if a group of providers are experiencing large increases, then the total amount of available dollars must decrease. The method developed to balance the budget? It's called the Budget Adjustment Factor, or the "BAF". Refer to the next bullet.

The BAF
In our old cost based system, if the State needed to apply budget cuts, they often went to a method referred to as the "across the board decrease". The BAF is exactly the same concept. It effectively applies an across the board decrease to all provider rates so that the total amount projected to be paid equals the total amount the State has allotted for our long term care budget.

The Phase In
The initial phase in was extended by six months. When we moved to the 50% old system - 50% new system blend the State had to apply a BAF, as more facilities were doing better under the new system and they had to limit the total dollars paid out to the budget. When we move to the phase, 25% old system - 75% new PPS system, we again expect that a number of providers will receive higher calculated rates which means the BAF must increase as well.

Rebasing
All of these factors create uncertainty for facilities attempting to project future rates. However, the biggest unknown factor surrounds rebasing. Our new system began January 1, 2015 (Rate Year 2015). By regulation the system is to be rebased every two to four years. So the earliest rebasing would be Rate Year 2017 and the latest would be Rate Year 2019. What effect would a rebasing have? And why do we even need a rebasing?

The purpose of the rebasing is to establish the prices of our PPS system. The prices that were established in January of 2015 were increased July 2015 based on the market basket and will increase again July 2016 based on the market basket. But these annual market basket increases may or may not reflect the actual spending patterns of facilities around Maryland. For that reason, when we rebase, the State will recalculate the medians and re-establish the prices. The concern about rebasing sooner rather than later is that facilities are already experiencing rate volatility as the new system phases in and matures. A rebasing that could involve a material redistribution of budget dollars would make an already difficult to manage system even more unwieldy.

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We will be talking about these and other topics at our annual reimbursement seminar on July 20th. Until then, if you need help with your budget or rate projections, or Case Mix assistance from our team that includes nursing, business office and reimbursement experts, give me a call at 410-494-9517 or email jschiavi@schiavi-wallace.com.

Wage index volatility continues to impact providers in Maryland.

Medicare Skilled Nursing Facility Prospective Payment System

Projected FFY 17 Rates and Other Initiatives in the Proposed Rule

By: Dawn Rowe, CPA, MBA, CPC

The Centers for Medicare & Medicaid Services (CMS) issued their proposed rule related to SNF Medicare payments for Federal Fiscal Year (FFY) 17 beginning October 1, 2016. In addition to the proposed payment update, CMS also provided more details on SNF Value Based Purchasing Program (VBP) scheduled to impact payments 10/1/18, and the reporting of SNF Quality Measures beginning 10/1/16.

Proposed Payment Change: Will we ever get the wage index fixed?
The overall proposed payment update effective 10/1/16 is 2.1%. This is before the impact of the area wage index affecting 68.9% of the payment rate. Therefore, as always, actual payment changes will vary widely across Maryland.

The projected payment change is based on the following:

Market Basket Adjustment	+2.6%
Multi-Factor Productivity Adjustment	(.5)
Total Proposed Payment Update	+2.1%

However, due to the wage index, the actual proposed payment change by Maryland region is very different from the overall Federal rate update. The proposed rate change for FFY 17 as compared to last year's actual change is summarized below:

Core Based Statistical Area (CBSA)	Proposed 2017 Change	Actual 2016 Change
Allegany/Cumberland	-13.54%	+4.14%
Baltimore	-1.20%	-2.25%
California/Lexington Park (St. Mary's)	-2.63%	+7.93%
Hagerstown	-1.78%	+.13%
Salisbury (Worcester)	+6.56%	+4.32%
Silver Spring-Frederick-Rockville	+1.80%	-5.58%
Washington	-.35%	-.31%
Wilmington (Cecil)	+2.56%	+2.10%
Rural	-.19%	+.23%

As can be seen from the chart, the wage index continues to greatly impact Maryland's SNF Medicare rates. While it is meant to adjust the Federal PPS rate for the difference in area wages, it is clear that the wage index as currently calculated is not truly a reflection of this. Wages simply do not change to this degree in a single

year, and the volatility created by CMS' continued use of the current wage index, which is based on wage data reported by area hospitals on their Medicare Cost Reports, presents annual budgetary challenges to SNFs.

While CMS has explored alternatives to the use of the current wage index, no meaningful progress has been made towards the adoption of a new labor adjuster. Many interested parties, including AHCA, have asked CMS to consider the development of a SNF specific area wage index, but CMS has resisted such a change citing the lack of resources to audit the SNF wage data. As a result, AHCA recently asked SWR to assist them in the development of a SNF wage index, using hospital cost report data, modified to SNF specific areas. AHCA intends to discuss the results of this model in a public comment to the proposed rule. CMS is currently accepting comments on the proposed rule from all interested parties until June 20, 2016. To submit a comment online go to http://www.regulations.gov and search for regulation 0938-AS44, and click "Comment Now". Comments may also be submitted by regular or express mail, and by hand delivery.

Medicare pay for performance will begin to impact payments in the next two years.

SNF Value Based Purchasing (VBP) – More Details Emerge

The proposed rule also includes more information on Medicare's version of pay for performance which will begin to impact payments effective 10/1/18, just over two years from now. This may seem like a ways away at this point, but the first period upon which performance will be based is proposed to begin January 1, 2017 and last the entire calendar year. There will be just one performance measure: the rate of hospital readmissions from the SNF. SNFs will be ranked based on the greater of performance or achievement. Therefore, a SNF's performance in calendar year 2017 will be compared to a baseline period to determine how well it performed or improved since the baseline. CMS proposed that the baseline period against which a SNF's performance will be compared will be calendar year 2015.

SNF Value Based Purchasing Key Term	Definition
Performance Measure (Initial) (Finalized)	30- Day All Cause, All Condition, Unplanned, inpatient hospital-readmission from a SNF within 30 days of hospital discharge
Baseline Period – For Measuring Performance	Calendar Year 2015 (Proposed)
Performance Period	Calendar Year 2017 (Proposed)

In order to score and rank SNFs CMS is proposing to award points for both achievement and improvement. To score achievement points, CMS is proposing an "achievement threshold" of at least the 25th percentile of SNF's performance on the measure nationally. Interpreted another way, 75% of all SNFs could receive achievement points.

The improvement scoring would be based on how an individual SNF performed on the readmission measure versus the baseline period (also known as the improvement threshold), relative to a benchmark. The benchmark CMS is proposing is the mean of

Benchmark for performance measurement will be calendar year 2015– your benchmark is already established!

the top decile of all SNF's performance on the measure during Calendar Year 2015. If a SNF's performance improves over its baseline, than it can earn points. If it scores greater than the benchmark, than maximum points can be awarded.

The final score earned will be the greater of the achievement or improvement score.

SNF Value Based Purchasing Key Term	Definition
Achievement Threshold	The 25th percentile of national SNF performance on the measure (hospital readmission rate) during CY 2015
Benchmark	The mean of the best decile of national SNF performance on the measure during CY 2015
Improvement Threshold	The specific SNF's performance on the measure during CY 2015

VBP will be funded by an overall 2% reduction in Federal Payments beginning 10/1/18 with 50% - 70% being returned as incentive payments to performers. Individual SNFs will be informed of their value based adjustment 60 days prior to the payment year. Still to be determined is the distribution of payments to performers (only the top 60% will receive incentive payments), the content and format of confidential feedback reports that CMS must provide to SNFs, and what CMS will do with the 30% - 50% of payment reductions not redistributed to SNFs.

SNF Quality Reporting Program (QRP) – Additional Measures Added
Quality measure reporting begins 10/1/16 on the three measures previously finalized last year. These include:

Finalized Quality Measure	Initial Reporting Period	Data Submission Deadline
Percent of Residents with New or Worsened Pressure Ulcers (Short Stay)	10/1/16-12/31/16	May 15, 2017
Percent of Residents with One or More Major Injury (Long Stay)	10/1/16-12/31/16	May 15, 2017
Percent of Long-Term Care Hospital Patients with Admission and Discharge Functional Assessment and Care Plan that Addresses Function	10/1/16-12/31/16	May 15,2017

Reporting on quality measures will begin to impact payments beginning 10/1/17. The data will be collected using the MDS, and new fields will be required for discharges from Medicare Part A. SNFs must report all data for the quality measures for at least 80% of the MDS' submitted. If the 80% threshold is not met (80% must contain 100% of the required data), the market basket update will be reduced by 2%. Quality Measures will be made available to the public.

In the proposed rule, CMS discussed the proposed FFY 2019 data collection period for the above measures (quarterly for Calendar 2017), as well as the submission deadlines. In addition, they proposed the adoption of four additional quality measures:

Proposed Quality Measure	Potentially Affecting Payments
Medicare Spending Per Beneficiary	FFY 2019 (10/1/18)
Discharge to Community	FFY 2019 (10/1/18)
Potentially Preventable 30-Day Post Discharge Readmission	FFY 2019 (10/1/18)
Drug Regimen Review Conducted with Follow-Up for Identified Issues	FFY 2020 (10/1/19)

CMS noted that additional clinical staff time will be required to report on these measures.

CMS also briefly commented on its ongoing contract with Acumen, LLC to explore different ways to pay for therapy services in the SNF PPS. This is part of an overall focus on Medicare Part A SNF payment reform.

As usual, Medicare payments are sure to be anything but stable over the next several years due to these various initiatives. Join us for our Annual Reimbursement Update co-hosted with HFAM on July 20th for a more in-depth discussion of these and other issues affecting your operations in today's quality based environment.

Please join Schiavi, Wallace & Rowe and HFAM

at our

Annual Reimbursement Update

July 20, 2016

To be held at

Turf Valley

2700 Turf Valley Road Ellicott City, MD 21042

Get the latest on:

- Maryland Medicaid PPS and Case Mix Optimization
- Medicare's Proposed Payment Changes
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