Schiavi, Wallace & Rowe, PC

Certified Public Accountants

A newsletter dedicated to long-term care providers.

Update on Medicaid Rebasing and the State Budget

Rates are due out any day...
How did your facility fare?

by Judith M. Schiavi, CPA, MBA

Maryland Medicaid received a 3% budget increase for rate year 2019. How much will your facility receive?

Maryland Medicaid Prospective Payment System (" PPS")

In January 2015, Maryland Medicaid transitioned to PPS. This payment system was radically different from the old cost based system in several ways;

- The new system is prospective rather than retrospective (ie: no final settlement).
- The new system pays a "price" for each day of service. The price is designed to pay facilities the same rate for the same service rather than recognizing differences in cost structure.
- The nursing rate is adjusted for acuity based upon case mix calculated using RUG -IV rather than our old home grown acuity standard.
- The acuity is quantified at the facility level rather than the patient level.
- Nursing profit is limited to 5% of the price. Profit in other cost centers is unlimited.

While the State adopted a system that provides it with much greater predictability when it comes to budgeting, facilities have had to deal with rates that varied widely from quarter to quarter. That instability was the result of a case mix system that was not "mature". Facilities had a great deal to learn about accurate reporting for the Medicaid population under RUGS and many continue to struggle with that change. As facilities learn and adapt to the new system, Statewide case mix has "creeped" higher despite no overall change in population acuity. The total base year facility case mix used in our current interim rates is 1.0721. The total base year facility case mix that will be used in our 7/1/18 rates is approximately 1.1622--a growth of 8.4%!

The Impact of the State Budget

The good news for rates beginning 7/1/18 is that our long term care budget was awarded a 3% increase! This is the largest increase we have had since 2012. The bad news is that not every facility will receive the full 3%. The 3% goes into the total pool of dollars used to fund the system. The amount your facility will receive will depend upon; the rebased prices in your region, your case mix, the relationship of your nursing costs to the nursing floor, your appraisal history, and finally--your real estate tax and provider tax expense.

What exactly is Rebasing?

Current rates, or "prices", were developed from 2012 cost data indexed forward. Those indices may—or may not—have reflected actual changes in spending by region and by cost center. In anticipation of the need for a periodic update of prices, the State put into regulation that the new system had to be rebased every two to four years. The rates for 7/1/18 will be updated with prices calculated from 2016 cost report medians. This is the reason for the recent audit of 2016 cost reports by Myers & Stauffer.

What will the 7/1/18 rebasing that updates prices from 2012 to 2016 mean for your facility?

The tables below reflect the changes in prices for Other Patient Care ("OPC"), Routine & Administrative ("R&A"), and Nursing:

Need help understanding your Medicaid rates? Contact Judy Schiavi at jschiavi@schiavi-wallace.com

OPC

Region	RY 2018 Price	RY 2019 Price	Change
Balto	$ 20.21	$ 18.45	$ (1.76)
Balto City	$ 22.21	$ 17.83	$ (4.38)
NonMetro	$ 18.77	$ 18.13	$ (0.64)
Wash	$ 20.65	$ 17.13	$ (3.52)

R&A

Region	RY 2018 Price	RY 2019 Price	Change
Balto	$ 81.73	$ 83.53	$ 1.80
Balto City	$ 86.93	$ 89.73	$ 2.80
NonMetro	$ 74.40	$ 72.43	$ (1.97)
Wash	$ 81.69	$ 80.69	$ (1.00)

NURSING

Region	RY 2018 Price	RY 2019 Price	Change
Balto	$ 142.07	$ 135.69	$ (6.38)
Wash	$ 134.82	$ 136.70	$ 1.88
NonMetro	$ 133.47	$ 130.76	$ (2.71)
Central	$ 132.90	$ 134.64	$ 1.74
West MD	$ 114.12	$ 115.07	$ 0.95

Medicare announced a 2.4% Increase for FFY19. But don't forget that VBP will take 2% away to be redistributed to top performers. Your facility increase could be higher or lower depending on your SNFRM scoring.

Other Changes in Medicaid Rates 7/1/18

As always, the State will incorporate the standard new rate year changes: new appraisals received by May 1 will be included, real estate taxes will be updated to reflect the taxes reported on the 2017 cost reports, case mix will be recalibrated, and the quality assessment (provider tax) model will be updated to reflect 2017 taxable census days and updated rates.

And Finally, the BAF

Once the new prices and other updates are included in the model, the State will multiply each facility's new rate by the estimated Medicaid days for next year, and determine whether funds are available to pay those rates. Historically, that has NOT been the case, resulting in the need for a Budget Adjustment Factor, or "BAF".

The BAF adjustment increased multiple times from 7/1/15 to 7/1/17 as a result of appraisal increases and case mix creep. As the prices from the rebasing reflect an overall decrease, this will be the first time that the BAF has reduced since the new system began. It is not projected, however, to go away. We still expect to see a BAF somewhere around .98, meaning the system will still be 2% underfunded, even after the 3% added for the new rate year.

Major Changes Coming to SNF Medicare Pt A Reimbursement

by Kurt Schaeffler, CPA

Based on the proposed skilled nursing facilities' prospective payment system rule issued April 27, 2018, major changes are coming to Medicare Part A reimbursement for rates beginning in both October 1, 2018 and 2019. Beginning October 1, 2018, SNF's will be following in the steps of acute care hospitals with the implementation of a value-based purchasing adjustment to RUG-IV payments. Then, on October 1, 2019, the Resource Utilization Group (RUGs) system we have known since 1998 will be replaced with a revised case mix methodology labeled PDPM, or Patient-Driven Payment Model.

<u>October 1, 2018 Value-Based Purchasing (VBP) Program</u>

From the beginning of SNF PPS, there have been annual adjustments to the payment rates (RUG case-mix categories) to account for market basket increases and the wage index application to the labor portion of rates. In recent years, we have also seen increases in the number of resource utilization groups, as well as additional rate adjustments to account for the forecast error adjustment factor and the multifactor productivity adjustment. More recently, the implementation of the SNF Quality Reporting Program (QRP) (IMPACT Act) resulted in the requirement for SNFs to report data on measures and resident assessment data. Noncompliance would result in a 2% reduction in payments.

PDPM is the biggest change in Medicare Part A since the beginning of PPS in 1998. With only 16 months to prepare, facilities must be proactive in learning about this new system.

For payments beginning October 1, 2018, SNF Part A case-mix rates will be adjusted by yet another factor. As part of Protecting Access to Medicare Act of 2014 (PAMA), a Value-Based Purchasing Program was required to be implemented which rewards SNFs through increased case-mix payments based on "30-Day All-Cause Readmission Measures (SNFRM)". These increased payments will be an additional factor in the calculation of RUG-IV payment rates, whereby each SNF will receive a different score that factors into their payments. Based on the scoring (zero to 100), SNFs are assigned values for their improvement from the baseline period (calendar 2015) to the performance period (calendar 2017) and their achievement in the performance period. Therefore, no longer will your case-mix rate be the same as the SNF next door (same CBSA adjusted RUG) because performance scores will vary by SNF. In arriving at your final payment rate, each case-mix rate will be reduced by 2% and the resulting amount will then be multiplied times each SNF's published value-based incentive payment adjustment factor. At the time of the publication of the proposed rule, Urban and Rural case-mix RUG rates were included but not the value-based incentive payment adjustment factors for each SNF.

The SNF VBP Program builds on previous Medicare quality improvement efforts both in nursing homes and in other care settings. Through SNF VBP, CMS estimates that $527.4 million will be withheld from SNFs' payments for FY 2019 with an additional 60% being paid back to SNFs creating a substantial savings to the Medicare Program.

<u>October 1, 2019 Patient-Driven Payment Model (PDPM)</u>

SNF PPS regulations address the replacement of the current RUG system, which is a combination of "resident characteristics and service intensity metrics", with a "patient-driven payment model" effective October 1, 2019. This new proposed model is based on CMS concerns that currently, residents receive "just enough therapy to surpass" lower paying case-mix categories and that there "is a strong indication of service provision predicated on financial considerations rather than resident need". MedPAC and OIG reports also substantiated a need for changing the current system that would better reflect each resident's care needs. As a result of this, Acumen LLC, the CMS contractor, arrived at an alternative model to the existing payment system named the Resident Classification System Version I (RCS-I), now known as PDPM.

The proposed PDPM would use ICD-10 and procedural codes to classify SNF residents into PDPM Clinical Categories, which would then be used to further classify the resident for payment purposes under PDPM. As a result of the new model, the current nursing case-mix rate component will be split into two separate components (nursing and non-therapy ancillary) and the current therapy case-mix component will become three separate therapy components (PT, OT & SP). As opposed to RUG-IV, in which a resident's classification into a single group determines the case-mix index and per diem rate, PDPM will classify a resident into separate groups for each of the new case-mix adjusted components where all components are eventually added together to determine the full per diem rate for a given resident. Data sources that will be used in the development of the final PDPM include Medicare enrollment, Medicare claims, assessment and facility data.

Many questions remain as to what the final PDPM model will look like, including what system changes and "groupers" will be required to capture and monitor new case-mix activity. We, as an industry, will need to continue to monitor on-going PDPM activities using our associations and CMS resources (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.com).

Schiavi, Wallace & Rowe PC is a full service public accounting firm providing services only to the healthcare industry. Need help with cost reporting? Rate projections? Audits or other lender requirements? Contact us at 410-494-9517

Electronic Signature and MCRef

by Kurt Schaeffler, CPA

Want to expedite your Medicare Cost Report filing process and receive a timely acceptability notice from your Medicare Administrative Contractor (MAC)?

Electronic signature is now an option in the Medicare Cost Report software when finalizing cost reports. Through this process, you or your cost report preparer will be given three "signature options" when finalizing the cost report (i.e. encryption). The options are 1) "wet signature"; 2) signed by preparer (who must be CFO or Administrator; or, 3) signed by CFO or Administrator whereby preparer is someone other than CFO or Administrator. In a majority of cases, numbers 1 or 3 will be the selected options. Option 1 is similar to the current process, where an "encrypted" (date and time stamp) certification page is generated and the CFO or Administrator signs in ink. Option 3 is new and allows the preparer to send the cost report to the CFO/Administrator for their electronic signature which is generated after he or she has accepted the cost report. The result is the preparer receiving the encrypted signature page back from the signer along with the print image of the cost report and encrypted cost report file. These items are then included with the Medicare Cost Report package sent to your MAC.

Not to be confused with the electronic signature option, the Medicare Cost Report E-Filing (MCRef) portal will be available for cost report filings beginning July 2, 2018. With this implementation, individual MAC portals will no longer be available and providers will have the option to electronically submit cost reports along with required supporting data via the MCRef portal. MCRef will have a straightforward user interface with just one screen and submissions will result in quicker acceptability and feedback from your MAC. In order to utilize the MCRef portal, a provider must have current EIDM credentials. Therefore, providers and NOT your consultant, can initiate the MCRef filings by submitting the full cost report package via the portal.

Save the date!

PLEASE JOIN US ON JULY 24th FOR OUR ANNUAL REIMBURSEMENT UPDATE

Our team will be updating you on various topics in Medicaid and Medicare, including;

- Rebasing, what we know now that we wish we knew then
- Medicare pay for performance (Value Based Purchasing " VBP") and how it will affect your OCTOBER 1, 2018 rates
- Medicare wage index updates and how it will affect your OCTOBER 1, 2018 rates
- Medicare Patient Driven Patient Model (PDPM). Yes, another acronym and a WHOLE NEW SYSTEM effective OCTOBER 1, 2019
- Medicaid MDS Clinical Validation Updates
- Electronic filing of Medicare reports
- HB 1215 Advance Payments
- And More!

Registration information available at www.HFAM.org

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