Schiavi, Wallace & Rowe, PC

Certified Public Accountants

A newsletter dedicated to long-term care providers.

It's Time to **Re-base** Maryland Medicaid !

What will this mean for your facility rates?

by Judith M. Schiavi, CPA, MBA

Any time we make a change to our system, including re-basing, there will be winners and losers

Medicaid PPS, the History

Maryland Medicaid began the transition to a price based prospective payment system on January 1, 2015. The original prices in our system were developed using 2012 cost report data which was indexed forward to Rate Year 2015. We started out the new system by combining old cost based rates with newly developed PPS rates, gradually increasing the PPS portion over time.

Every year on July 1 the PPS system prices were increased by the market basket, new appraisals were added in, and the case mix data was recalibrated to account for the growth related to better MDS capture by the industry.

As quarterly Medicaid case mix increased, nursing rates also increased, with the end result being that our system was generating rates in excess of the State budget. The Department began using the budget adjustment factor, or the "BAF" to apply an overall reduction in rates in the amount required to equal the State's total budget. As of July 1, 2017, the BAF was .90348, meaning that current rates are decreased by almost 10%.

Selection of New Base Period

By regulation, the Department must "re-base" every two to four years. The State recently announced that 2016 would be the new base year period and it would be used for payment rates beginning July 1, 2018.

This means that the 2016 report data will be used to restate minimum occupancy as well as identify the medians and related prices for the Other Patient Care, Routine & Administrative, and Nursing Regions. The re-basing does not affect the calculation of the capital rate which comes from appraised values.

This also means--just as importantly, that your total facility case mix will be updated to reflect the average total facility case mix covering your 2016 cost report. The Statewide average total facility case mix will be updated to reflect overall 2016 total facility case mix as well. Our early predictions are that Statewide average case mix will increase from 1.0721 to about 1.1637, which demonstrates just how much case mix growth this new system has precipitated.

The State has indexed our 2012 cost data forward every year in anticipation of current spending patterns. But after 4 years of indexing, those results are unlikely to mirror actual spending, especially given the number of regions we have in our small State

Desk Reviews

The State also shared that the 2016 cost reports will be desk reviewed to validate the numbers before they are used to update the prices. Early letters from Myers and Stauffer are requesting full general ledger detail, salary and payroll tax reconciliations, confirmation of employees covered in the nursing wage survey, along with explanations of expense fluctuations from the prior year and specific questions on cost report adjustments. Once Myers receives that information, they may ask for additional invoices supporting certain accounts based upon your prior year audit history or questions that come up during the review process.

We have been told that Myers intends to complete all the desk reviews by the end of March 2018, so that the desk reviewed numbers can be sent to the State for the calculation of the Rate Year 2019 model that goes into effect July 1, 2018.

How much time facilities will have to protest adjustments, and how that protest may or may not affect the numbers used in the July 1, 2018 model remains to be seen. This is all new.

Nursing is Especially Complicated due to Normalization, "the Carve out", and the Floor

The purpose of a price based system to is to pay every provider the same amount for the same service. The system encourages efficiency by allowing providers to keep any savings they may earn from spending below the price levels in Other Patient Care and Routine & Administrative. However, the nursing cost center has a floor so that providers do not economize to the point where it becomes a risk to patient care. The floor is 95% of the price; the nursing profit is limited to 5%.

The first step in calculating a nursing price is the "normalization" of the acuity. Each facility's total acuity is compared to the Statewide average total acuity, and the costs per patient day are adjusted by that relationship. Those "normalized" costs are what will be used in the median calculation that develops the prices, not actual costs.

For example, say that a facility in the Baltimore region has a very high cost high acuity building, perhaps $175 per day in nursing costs for a 1.45 case mix. This $175 per day would be divided by the 1.45, then multiplied by the Statewide total facility average 1.1637 case mix and the resulting $140.45 would be the value considered in the median calculation.

Once a price is established and the floor is determined, the State will compare your costs to the floor. Again, your nursing costs have to be adjusted as they relate to all your residents, yet the price is for Medicaid only. Your nursing costs will be divided by your total facility acuity and then multiplied by your Medicaid only acuity to identify Medicaid only costs. If these costs are lower than the floor, your price will be adjusted accordingly.

Traditional benchmarking studies are useless when it comes to predicting nursing prices for the various regions unless they incorporate the acuity data and mimic the normalization process. Providers need to be working with their consultants to make sure that they understand the factors that will drive the change in their rates on July 1, 2018.

The "Carve out" refers to the portion of nursing costs related to non Medicaid (typically higher acuity) residents. The larger the spread between your total facility case mix and your Medicaid only case mix, the more your nursing costs will be reduced in the floor calculation when comparing to 95% of the price

Other System Changes?

We have now lived with this new system for a little over two years. Since we are re-basing, this is the perfect time to look at the system as a whole and see if it is operating the way that it was intended.

Some areas that we believe should be re-examined include;

1. The indexing of the appraisal ceiling. Through the BAF mechanism, providers operating at or above the ceiling have actually experienced rate decreases due to the growth in the appraisal rates of those operating below the ceiling. This problem could be alleviated by applying the same market basket increases used for the prices to the appraisal ceiling.

2. Regional realignment. The regions being used in this system were originally developed more than twenty five years ago, and Maryland census data has changed. Furthermore, Maryland is a small State and having too few facilities in a particular region can cause wide fluctuation in price development. It is time to take a closer look at this issue.

3. Electronic wheelchairs are being factored into our total budget (and reducing the dollars available for routine care). When facilities were first allowed to bill the program for electronic wheelchairs, only a few were authorized every year. In Rate Year 2018 this grew to more than $1million in authorizations and the growth for Rate Year 2019 is expected to be much higher. While there are residents for whom electronic wheelchairs are a critical part of their care, the chairs don't belong to the industry so they really shouldn't be coming out of our budget.

What is Important to Know about Re-basing?

This is a complicated system and things can and will change. While we have begun working on modeling the results of the re-basing, any models that are developed will have to be updated as the various factors affecting the July 1 rates become more widely known. For example, at this time we don't know how much the desk reviews will impact the 2016 cost report data. We don't know how much our budget increase will be. We don't know how much new appraisals rolling into this rate year will cost the system. We don't know if the State intends to look at regional realignment issues or other system changes. We don't know how much case mix will continue to grow. All of those issues will affect future rates. What we do know, is that anytime a system changes, there will be winners and losers.

What will determine whether you win or lose on re-basing?

- Your nursing cost growth from 2012 until 2016 as compared to the market basket
- Your total facility acuity and "carve out" changes from 2012 until 2016
- The changes in Other Patient Care and Routine & Administrative spending in your region as compared to the market basket.

If you have any questions about re-basing and your facility, please do not hesitate to contact me at jschiavi@schiavi-wallace.com or 410-494-9517, ext. 105.

PLEASE JOIN US
IN OCEAN CITY
at the HFAM/LIFESPAN Conference
FOR OUR 'TEAM' PRESENTATION

Tuesday October 24th at 7:30 AM

(and yes that is pretty darn early so bring your coffee!)

Our Accounts Receivable and Business Office Manager, Donna Culberson, will be sharing with you tips and suggestions developed from her daily interactions with our clients.

Judy Schiavi will be at the session and will be happy to answer any questions you have on re-basing or other issues related to your Medicaid or Medicare reimbursement. See you in OC!

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