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Certified Public Accountants

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Maryland Medicaid PPS and "Shadow Rates"

One Step Closer

By Judith M. Schiavi, CPA, MBA

The Department of Health and Mental Hygiene released a draft proposal on August 27, 2013 outlining specific provisions of the Medicaid Prospective Payment System (PPS) expected to go live July 1, 2014—just TEN MONTHS from now.

The new PPS system as it is currently modeled is a price based system which is intended to reimburse facilities for the value of the services performed rather than the costs they incur. This is very unlike today's cost based reimbursed system which can reimburse two different facilities for taking care of exactly the same patient at widely differing rates. Maryland is in fact the last state in the country with a full cost based retrospectively adjusted system—something that the Department is determined to change by next fiscal year.

The new PPS system is designed to be budget neutral. The Department hopes that it will provide better predictability for State budgeting with the elimination of the cost settlements. So, while the total dollars in the Medicaid long term care program will stay the same-- the distribution of those dollars among long term care providers is going to result in winners and losers in the industry.

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The Cost Centers Under PPS

The cost centers and their components will continue to be familiar—Nursing, Other Patient Care, Routine & Administrative, and Capital, however the calculation of the "prices" and ultimate payments for each will vary dramatically from the system that we have become used to over the past twenty five years.

Nursing

Nursing "prices" (using the same five regions we have today) will be subject to a floor and will be adjusted quarterly to account for changes in facility acuity. Expect your MDS Coordinator to be kept busy monitoring your total facility Case Mix Index (CMI) and your Medicaid only CMI using the RUG IV 48 grouper with CMS standard weights and index-maximization. This is important because the price for each region is calculated assuming an average total facility case mix and an average Medicaid case mix. If your facility acuity is higher or lower than average, you can expect corresponding adjustments to your price or rate.

You might think that because the proposed system is going to a RUGS based system, that you will end up with 48 different Medicaid rates, similar to the way our Medicare system works.

Each quarter's Medicaid rate (only one rate for every patient in your building) will reflect an average acuity for ALL of your Medicaid residents.

However, that is not the case as the Department plans to use a "day weighted approach" for calculating CMI scores. On the back page of the quarterly patient rosters that have recently been sent to your facility, you will see a calculation of the day weighted total facility CMI and the day weighted Medicaid only CMI. Each quarter's Medicaid rate (only one rate for every patient in your building) will reflect an average acuity for ALL of your Medicaid residents. Keep in mind that there will be a significant time lag involved in the acuity adjustments as your facility will be given 20 days to review each quarterly roster before it is used in the next rate update.

Similar to our current system, there is a potential profit factor built into the nursing cost center. Your facility may keep up to 5% of the rate as profit by spending below the "price" determined for its acuity. However, the State also plans to eliminate any incentive for aggressively cutting nursing costs by implementing a floor which lowers the rate for facilities spending below that 5% profit factor.

Other Patient Care

Most facilities are underpaid in Other Patient Care in the current system, as our ceilings have remained largely unchanged since 2009 while costs in this area (food, recreational and social services) have continued to rise. Therefore the proposed "price" at the median plus 7% will likely result in an increase in your rate for Other Patient Care. The price in Other Patient Care is just that—what your facility will receive no matter your actual spending and no matter your actual acuity. The result is that facilities which are able to spend below that price may keep the savings as a profit factor.

Routine and Administrative

Beware! Facilities which have routinely spent above the Routine and Administrative Ceiling are going to see a decrease in their Routine and Administrative rates. The new Routine and Administrative "price" will be set at an amount that is slightly above the median (currently proposed at 2.75%) which is much less generous than our existing ceilings that are median plus 12%. Furthermore, the Department plans to "reset" the system using current cost reports-- facilities in general have DECREASED spending in this area as a direct result of the past four years of tough budget cuts. These two factors are resulting in the decrease in rates for any facility currently over the ceiling—and these reductions could amount to more than $8 per patient day. Again, similar to Other Patient Care, the Routine and Administrative "price" for each region is your final rate—any facility which is able to spend below that price may keep the savings.

Capital

Capital is undergoing a total restructuring moving from a net capital value system that reimburses facilities for debt and equity to a fair value system that reimburses on total appraisal value plus a pass through for real estate taxes (and provider tax) only.

As with the current system, there will be limits on the amount of the appraisal that can be reimbursed, but these limits are much higher. The appraisal ceiling is proposed at $100,000 per bed, much higher than our current $74,352 and $6,561 for the total land, building and equipment allowances. Facilities that are likely to have higher capital rates under the new PPS would be facilities with very low interest rates and facilities that have appraisals higher than current ceilings.

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Unlike the costs in other cost centers, it is very difficult for facilities to make operational changes that will influence capital costs. Many providers are locked into long term leases or mortgages with large prepayment penalties. Therefore it is critical that you immediately assess the impact of this change in capital rate as it relates to your building.

Re-basing

While our cost reports will no longer be used to determine final settlements after June 30, 2014, they remain important inputs to the new PPS system. Cost reports will be reviewed annually to set interim rates (especially important for that floor calculation in nursing), and will be used to re-base medians and reset prices every two to four years.

The Phase-In

You may remember when PPS came to the Medicare program that the new system was "phased-in" in order to allow facilities to have time to make operational changes to deal with the changes in payment rates. Similarly, it is the Department's intent to phase-in the new Maryland Medicaid PPS System. The current proposal is two years; 67% existing system 33% PPS for year one (FY 2015) and 33% existing system and 67% PPS for year two (FY 2016) moving into 100% PPS by July 1, 2016. This seems to be a pretty short phase-in considering some of the rate swings that we have seen modeled so far.

What Happens to Pay for Performance and Quality Assessment?

Pay for performance awards are expected to move forward in the same way-and under the same measurement basis as in the current system. Similarly, the State will continue to assess and collect quality assessment (provider) taxes to supplement its overall budget.

What's Next in PPS Implementation?

Keep in mind that things are still changing!

The Department plans to issue "shadow" rates to each facility—sometime in the next month or so, enabling facilities to compare current reimbursement rates to proposed rates under the new system. While these rates will provide us with important information on the types of changes we can expect to see, it is important to **keep in mind that things are still changing. The Department plans to use feedback from the industry over the next months to continually tweak and improve the new Medicaid PPS system.**

If you have questions or concerns regarding how your facility will fare under Maryland Medicaid's new PPS, please call (410) 494-9517, ext. 105, or contract me at jschiavi@schiavi-wallace.com.

We understand that this reimbursement system change will require strategic planning and education and are available to meet with management and board of director groups to assist facilities in readiness planning.

PLEASE JOIN SCHIAVI, WALLACE & ROWE

at the joint HFAM/LIFESPAN Art of Caring conference

in Ocean City as we present

Maryland Medicaid PPS

Understanding your Shadow Rates

The Maryland Medicaid system is undergoing the biggest change in its reimbursement system since the original design twenty years ago. This session will review the components of the new system that have been agreed upon, the remaining challenges in the system development and will focus on how facilities can plan for and develop a plan to successfully transition to Medicaid PPS.

Our session is Wednesday September 25, 2013 at 9:15 AM

For more information about this conference go to:

www.mdltcconference.org

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