Schiavi, Wallace & Rowe, PC

Certified Public Accountants

A newsletter dedicated to long-term care providers.

Medicare SNF PPS Final Rule

Final FFY 16 Rates and Update on Other Initiatives

By Dawn L. Rowe, CPA, MBA, CPC

On August 4, 2015, The Centers for Medicare & Medicaid Services (CMS) issued their final rule related to SNF Medicare payments for Federal Fiscal Year (FFY) 16 beginning October 1, 2015. In addition to the payment update, CMS also finalized some portions of the SNF Value Based Purchasing Program (VBP), the SNF Quality Reporting Program (QRP) and staffing data collection submission, although many elements of these initiatives remain unresolved.

Payment Update

The overall payment update to SNF PPS rates effective 10/1/16 is 1.1%. This is lower than the 1.3% payment change in the proposed rule, mostly due to a revision in the projected market basket index (MBI). As usual, the actual payment update for Maryland facilities varies widely due to the impact of the area wage index which affects 69.1% of the payment rate.

The payment change is based on the following:

Market Basket Adjustment	+2.3%
Forecast Adjustment Error	(.6)
Multi-Factor Productivity Adjustment	(.5)
Wage Index Budget Neutrality	(.1)
Total Proposed Payment Update	+1.1%

However, due to the wage index, the actual payment changes by Maryland region are:

Core Based Statistical Area (CBSA)	10/1/15 Payment Change
Allegany/Cumberland	+4.39%
Baltimore	(.46)%
California/Lexington Park (St. Mary's)*	+7.28%
Hagerstown	+1.22%
Salisbury (Worcester)*	+4.05% to +4.40%
Silver Spring-Frederick-Rockville	(2.73%)
Washington	+.91%
Wilmington (Cecil)	+2.54%
Rural	+1.31%

Providing personalized accounting and consulting services exclusively to healthcare providers.

*Note that CMS adopted new CBSA delineations in FFY 15 that resulted in some areas changing CBSAs or new CBSAs being created. The new CBSAs will be fully implemented in FFY 16, resulting in large changes in some areas such as St. Mary's County and Salisbury.

The 2% sequestration adjustment continues to remain in effect.

For the actual payment rates for all Maryland regions, please visit our website at http://schiavi-wallace.com/medicare-rates.

SNF Value Based Purchasing (VBP)
In the final rule, CMS adopted the 30-day All Cause Readmission Measure as the initial performance measure for Medicare's version of pay for performance which will impact payments beginning 10/1/18. It will be based on all causes and conditions resulting in an unplanned hospital readmission within 30 days of discharge from a hospital. This performance measure will be replaced by an all condition risk adjusted potentially preventable hospital readmission rate at a later date. The measure will be based on claims, with no additional reporting requirements from SNFs.

This performance measure will be replaced by an all condition risk adjusted potentially preventable hospital readmission rate at a later date. ...

Much is still yet to be determined including performance standards (SNF scoring and ranking), the amount of the SNF incentive payments, and the public reporting of SNF performance. What we do know is that effective 10/1/18 the Federal per diem rate will be adjusted down 2% to fund the system, but only 50% - 70% of this will be awarded to the top performers. CMS is still considering what to do with the amount that will be retained.

SNF Quality Reporting Program (QRP)
CMS finalized the three initial quality measures for the SNF QRP that will also begin to impact payments on or after 10/1/18. These include: 1) Functional status, cognitive function and changes, 2) Skin integrity and changes, and 3) Incidence of major falls. Reporting will be done through the MDS. 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.

Staffing Data Collection
CMS officially added the mandatory submission of staffing information based payroll data as a condition of participation for long-term care facilities. Beginning July 1, 2016 all facilities must submit quarterly payroll data for direct care staff and contractors electronically.

Voluntary reporting will begin 10/1/15; CMS is encouraging participation to allow facilities to test their submission and receive feedback. Training and registration will be required. For more information, please go to the following webpage:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

Clinical Validation of MDS to Begin November 1, 2015

By Judith Schiavi, CPA, MBA

MDS Validation to Begin November 1, 2015
The State met with industry representatives to review the plans for clinical validation of the MDS. Originally scheduled to begin July 1, 2015 (six months after the start of the new Medicaid PPS payment system), the validation process was delayed and is now scheduled to begin November 1. The Department has planned for every facility in the State to receive its first review within that next twelve months (November 1, 2015 to October 31, 2016).

Population and Sample Size
Myers & Stauffer will go to your most recently available and finalized quarterly roster to select a sample of MDS for review. The sample size will be 20% of the roster or 10 MDS charts, whichever is less. While the majority of the sample will be Medicaid MDS (approximately 90%), the reviewers will also be looking at non-Medicaid MDS. The reason for this is to determine whether your MDS reporting varies between Medicaid and other payers.

Notice of Audit
When "your time is up", don't expect much in the way of notice. Auditors plan to give facilities only a few days advance notification, and the sample will be provided upon their arrival. Any documentation disputes are to be handled while the auditors are present at the facility, no documentation will be accepted at a later date.

Acceptable Error Rates
Myers & Stauffer will "re-rug" your MDS sample as a result of the audit. If your facility experiences a higher than 20% error rate, you will receive notification only. This first year is our "grace period"--a time to learn what the auditors are looking at and how to improve our MDS documentation. After this first year, an error rate of this magnitude will involve an expansion of the sample size and potential penalties with more frequent visits from the auditors.

Status of Quarterly Reviews from Delmarva
We thought we wouldn't be seeing them again once PPS began, but it turns out you are still going to have quarterly visits from Delmarva this year. While they are no longer checking your levels for billing purposes, we still need their help in handling continued stay reviews and PASRR validation. The State hopes to automate some of these functions in the MDS in the future.

How Can you Plan for Clinical Validation?
The clinical validation committee continues to work on the draft of the new Medicaid handbook which identifies best practices and recommended documentation by MDS 3.0 line item. Watch for publication of that document in the next few months. We will also share information on the audits as the process begins to roll out. In the meantime, make sure your employees are aware that the audits will be taking place, and that they understand the purpose of these reviews is to confirm that your documentation supports that you received the proper Medicaid payment based on the acuity documented in your MDS. Also ensure that employees do not confuse this clinical validation process with the new MDS Focused Surveys, which will also be taking place over next year. Those surveys, piloted by CMS in 2014, were designed to help strengthen the five star quality rating system by assessing MDS coding practices and its relationship to resident care. Deficiencies in the MDS Focused Surveys can result in citations and enforcement actions. Problem areas noted in the pilot were; identification and coding of restraints, failure to identify the correct pressure ulcer stage, failure to document the level of injury from a fall, and disagreement in late loss ADL status between the MDS and the medical records.

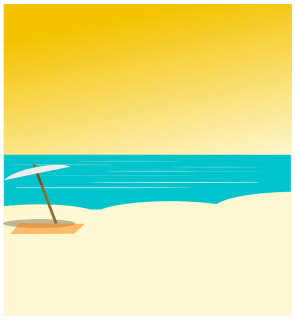
If your facility should be so unlucky as to receive notification of a MDS Focused Survey at the same time as Maryland's new clinical validation, speak up and ask for a delay of your Maryland review. We are fortunate to have been granted a penalty free review the first time around, so we need to make the most of it by learning and understanding the process that we can expect in future years.

If you have any questions about Maryland Medicaid PPS, contact me at jschiavi@schiavi-wallace.com.

VISIT US
October 20, 2015

Join Judy Schiavi and Dawn Rowe from Schiavi, Wallace & Rowe, PC on October 20, 2015 as we present our topic "***A Glimpse into the Future of Medicaid and Medicare for Long-Term Care***" at the Annual Lifespan Network and HFAM Joint Conference in Ocean City. We will be discussing the current status of Medicaid and Medicare PPS, along with alternative payment models for both Medicaid and Medicare, and how long-term care providers can position themselves for success in the changing landscape.

We look forward to seeing you in OC!



WE'VE MOVED

Our new address is:

Schiavi, Wallace & Rowe, PC
606 Providence Road
Towson, MD 21286

Visit our website at www.schiavi-wallace.com

Call us at 410-494-9517 or email us at: info@schiavi-wallace.com