

Provider Tax, Budget Cuts and Your Facility

What's it all Mean?

By: Judith M. Schiavi, CPA, MBA

There are lots of questions floating around about the status of proposed changes to our Maryland Medicaid reimbursement system:

I heard there are additional budget cuts, how will this impact my facility?

Yes, there have been additional budget cuts to Rate Year 2008. On top of the \$4.3 million (\$8.6 million in total funds when considering the Federal match) announced back in April, there was an additional \$4.3 million announced by the Governor in July (\$8.6 million in total funds). This second \$4.3 million is not an annual amount, but assumes (and is contingent upon) the enactment of a CMS approved Provider Assessment on October 1. On an annual basis, these two cuts are a little more than \$10 million (\$4.3 million first cut plus \$5.7 million second cut, or \$20 million in total funds).

The second cut was announced after rate letters went out, so you may be thinking that your interim rates will be adjusted—and you are correct. Your Medicaid rates will be revised, probably with an effective date of October 1, 2007, but those rates will be going up! This is because at the same time the new budget cuts are implemented, the State will also be using the provider assessment to fully fund the Medicaid program and cover part of its \$20 million dollar budget deficit.

To further complicate things, the definition of what makes up a “fully funded” system has also changed, as the State has taken this opportunity to make revisions to the system in areas that they considered to be inequitable.

What does our new “fully funded” system look like?

A breakdown of the changes, by cost center, is shown below;

Admin & Routine

Admin & Routine costs are currently reimbursed at 112.25% of the median costs of all facilities, with an efficiency allowance of 40% of the difference between cost and ceiling for providers whose costs are below the ceiling. These parameters are further reduced by a 1.4% overall reduction for budget cuts that began in FY 2007.

Under our new fully funded system, Admin & Routine costs will be reimbursed at 114% of the median, with an increased efficiency allowance of 50% of the difference between cost and ceiling. There will be no 1.4% reduction.

Other Patient Care

Other Patient Care costs are currently reimbursed at 118% of the median, with an efficiency of 25% of the difference between cost and ceiling. These parameters are further reduced by a 1.4% overall reduction for budget cuts that began in FY 2007.

Under our new fully funded system, costs will be reimbursed at 120% of the median, and there will be no 1.4% reduction. In addition, *OTC costs paid via arrangement will be allowable on the cost report.* This has been an inequity in the system for many years, due to the fact that most facilities have their OTC drugs privately billed by their pharmacies, which causes a distortion of the average Medicaid rate.

Nursing

The nursing efficiency is currently the lower of 3.15% of the provider's maximum allowable nursing payment, or 60% of the difference between payment and cost.

Under our new fully funded system, the efficiency increases to 4% of the provider's maximum allowable nursing payment. *In addition, the State will be reimbursing for negative pressure wound therapy.*

Capital

The rental rate is currently 8.22 %, with an appraisal ceiling at \$65,624 per bed. The rate is also reduced by a 1.4% overall reduction for budget cuts that began in FY 2007.

Under our new fully funded system, the rental rate will increase to 8.568%, and the appraisal ceiling will be \$69,672. Rather than the previous methodology of establishing the appraisal ceiling at a fixed value with annual inflation, the State intends to annually tie the appraisal ceiling to the amount covered by 50% of Medicaid days and adjust the rental rate to the value of capital dollars remaining. *The State also intends to cover the costs of bariatric beds and certain wheelchairs that are not currently reimbursed.*

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In Summary

Our newly defined reimbursement system will have higher ceilings, higher efficiencies, and additional coverage for OTC drugs, bariatric beds, certain wheelchairs, and negative pressure wound therapy. The details of how these newly covered items will be billed and reimbursed is still being worked out.

How these changes impact your facility depends upon your relationship to the current reimbursement ceilings. The State has calculated that the rate increases for providers will range from a low of \$1.82 per patient day to a high of \$6.58 per patient day.

I still don't understand how the provider assessment will allow me to have increased Medicaid rates, even though we have budget cuts.

The Federal Government currently supplements our State Medicaid budget with a 50% "match" of funds. A provider assessment is a plan implemented by the State to increase this Federal match.

Here's how the assessment process will work:

- Every provider will pay a "tax" to the State on all of their patient days, excluding Medicare. The tax amount that is currently estimated to fully fund our system and provide the State with its \$20 million, is \$5.22 per patient day.
- This tax will be an allowable cost, and the State will return a portion of the tax paid by providers as an increase in their average Medicaid rate.
- The State will use the additional Federal match generated to fully fund the system and supplement its budget.

If the tax that you pay to the State is less than the tax returned to your facility via your increase in allowable costs and your increased Medicaid rate from the fully funded system, then you are a "winner". Conversely, if you pay out more in tax than you receive in increased Medicaid funding, then you are a "loser". Generally, the higher a facility's Medicaid occupancy, the more likely they will be a "winner".

The good news is that out of the 234 providers that will be paying provider assessments, there are only 13 "losers".

When can I expect provider assessment to become effective?

The State has now submitted its request to CMS, and we expect to hear back on a pre-review basis within 30 days. At that time the State will submit their final request, which can take 90 days for approval.

The provider tax legislation allows that the provider assessment will become effective on the first day of the quarter in which approval is received from CMS. So assuming that final approval is received by December 31st, the assessment would become retroactively approved on October 1, 2007. Providers would expect to receive payment on revised interim rates, and then use those funds to pay the first quarter tax.

Still want to know more about provider tax? Join us at our session in September at the HFAM convention. Or if you have additional questions about provider tax and how it will impact your facility, you can contact me at jschiavi@schivi-wallace.com.

New Medicare Rates Effective 10/1/07 Published Increases Vary by Maryland Region

By Dawn L. Rowe, CPA, MBA, CPC

In the August 4, 2007 Federal Register, the Centers for Medicare & Medicaid Services (CMS) published the annual SNF PPS update, which will be effective 10/1/07. The overall market basket increase is 3.3%, but the actual increase in rates for your facility could be more or less than 3.3%. In fact, Medicare rate increases in Maryland will range from a low of just .07% for facilities in the Bethesda/Frederick/Gaithersburg area, to a high of 4.76% for facilities classified in the rural region. This is because in addition to the annual market basket update, the regional wage index that is applied to roughly 70% of the federal rates is also updated. If the change in the wage index for a particular region is negative than rates won't increase as much as the market basket update of 3.3%, if it's positive then rates can increase more than the market basket.

Below is a comparison of the current wage indices by Core Based Statistical Area (CBSA) and the new wage indices effective 10/1/07 (Federal Fiscal Year 2008):

MSA/CBSA	2008 Wage Index	2007 Wage Index	Difference
Baltimore	1.0134	1.0088	0.0046
Washington	1.0855	1.1054	-0.0199
Wilmington	1.0824	1.0684	0.014
Hagerstown	0.9013	0.9038	-0.0025
Cumberland	0.8294	0.8446	-0.0152
Rural	0.9034	0.8926	0.0108
Bethesda/Frederick	1.0511	1.0903	-0.0392
Salisbury	0.8994	0.8953	0.0041

The change in the wage index coupled with the market basket update of 3.3% results in the following rate changes effective 10/1/07:

Baltimore:	+3.50%
Washington:	+1.32%
Wilmington:	+3.81%
Hagerstown:	+3.64%
Cumberland:	+3.01%
Rural:	+4.76%
Bethesda/Frederick:	+0.07%
Salisbury:	+4.21%

To find out what region your facility is in, and for a listing of rates by RUG category, go to: www.schiavi-wallace.com, and click on the link for newsletters.

Wait a minute...those are big differences! What is the wage index again?

The area wage index is a Medicare specific index used to account for differences in area wage levels. Medicare uses the U.S. Census Bureau's CBSAs to determine wage index areas. A wage in-

dex of a 1.00 means that a region's wage index is in line with the national average; areas with a wage index greater than a 1.00 are generally areas where wage levels are higher than the national average, and areas with wage indices lower than a 1.00 are generally areas where wage levels are lower than the national average. For example, you would expect wages to be higher in the DC area than in Cumberland, therefore, the DC CBSA wage index should be higher than that of Cumberland.

The Medicare wage index is based on data collected from hospital cost reports in your CBSA. The hospital wage index has been used in the hospital Medicare payment system (except in MD) since the early 1980s. Although similar data is collected on SNF cost reports (refer to Worksheet S-3 Part II), SNF data has never been audited, and CMS feels that the development of a SNF specific wage index would require too much of an effort by its Medicare contractors. CMS repeated this in the August 4, 2007 SNF PPS update and stated that the use of the hospital wage index in the SNF PPS is "appropriate and reasonable".

What is the Market Basket and how is it used to adjust rates?

The Market Basket Index (MBI) is the inflation factor used to update the Federal rates annually. The SNF specific "Market Basket" is another Medicare index used to measure the change over time in the prices of the goods and services included in SNF covered services. Because the MBI update is done prospectively, it is actually a *forecasted* increase. CMS' previous policy included a provision whereby if the forecasted increase was different than the actual increase by more than .25 percent, than a forecast adjustment factor could also be applied in the next year's MBI adjustment. This adjustment could be either positive or negative. Although no forecast adjustment factor applied to the MBI used to calculate the FY 2008 rates, CMS decided that the threshold for any future forecast adjustment factors will increase to .50 percent.

In addition to changing the forecast adjustment factor threshold, for the 2008 rates CMS also rebased the MBI, previously based on 1997 data, to 2004, and changed the components of the MBI. The MBI is meant to include the most commonly used cost categories for SNF routine, ancillary and capital-related expenses. It contains 30 different cost categories, and related "weights" for items like wages, benefits, liability insurance, drugs, postage, interest, and depreciation. For the 2008 MBI CMS used Medicare allowable cost data, from Medicare Cost Reports, to determine market basket cost weights. Previously, CMS used facility total cost vs. Medicare allowable. So, if you were thinking your Medicare Cost Report is meaningless and has nothing to do with payment rates, think again!

One of the biggest impacts of all of this rebasing and revising of the MBI is its affect on the labor-related portion of the federal rates (the portion that the wage index is applied to). Specifically, the labor-related portion of the 2008 Federal rates is 70.152, which is down significantly from the labor-related portion of the current rates of 75.839. Therefore, 2008's rates are somewhat less impacted by year-to-year swings in the wage index than in previous years.

Consolidated Billing

Although CMS had asked for input on additional services that could be considered as exclusions to consolidated billing, no changes were made in the Final Rule. This is because CMS believes its authority to add services is limited to the existing categories of excluded services, and it can only add services representing new services or items that fall within the existing categories. For example, if there is a new chemotherapy drug that was not included in the original list of HCPCS codes excluded from the PPS, then it could expand the list. CMS stated that all comments it received related to additional codes were for services or items that were available back when the original exclusions were developed.

In addition, CMS received comments related to imaging services (such as MRIs and Cat Scans), that are excluded from the PPS only when provided in hospital outpatient departments and not in freestanding imaging centers. CMS refused to budge on this issue as well, stating its position that the services have to be of the intensity to require a hospital setting to be considered beyond the scope of SNF care, and therefore eligible for exclusion from consolidated billing.

For questions related to Medicare payment rates or consolidated billing, please contact me at drowe@schivi-wallace.com and be sure to attend our Medicare update session at HFAM's annual convention.

Electronic Cost Reporting Now Mandatory for Maryland Medicaid

By: Judith M. Schiavi, CPA, MBA

Changes to Cost Reporting Requirements

Effective for June 2007 year ends, all long term care providers in Maryland must file Medicaid cost reports electronically. This change has been in the works for several years and represents a culmination of efforts from State officials, the State's technology arm at UMBC, Myers & Stauffer management, and provider/industry representatives.

Providers have the choice of downloading an electronic file from Myers & Stauffers' website at www.mslc.com, modifying their own electronic cost reports to be consistent with this revised cost report, or entering data directly into the UMBC nursing home cost report website (www.dhmuhr.org).

We have tried both downloading the electronic file and doing direct input onto the UMBC website. At this time we have found the downloaded file to be much easier to use than the UMBC website.

Note to users: All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the facts of the particular situation.

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Changes to UCR General Instructions

The cost report instructions have been modified to include details about the new cost reporting process. If you haven't read the instructions lately, now might be a good time to download these from www.mslc.com. While the due dates for cost report submission remain the same, both the electronic cost report and a signed copy of Schedule A along with other attachments (questionnaires, new debt information, if any, and financial statements or trial balances) must be received in order for the submission to be accepted.

A new complication is the "final review certification" for anyone not entering data directly on the UMBC website. After Myers & Stauffer has uploaded your cost report onto the UMBC website, you have only 5 days to review and "certify" that the upload is an accurate transferal of your cost report information.

So what's another deadline, right?

As with any conversion of manual to electronic processes, we expect that there will be some "hiccups" along the way. However, electronic filing will eventually provide the industry with faster, more reliable data—data that is critical as we move into future years with potentially large budget deficit problems.

Have questions about your cost report? Contact me at jschiavi@schivi-wallace.com

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