

New Medicare Rates Effective 10/1/09 Published: Most Areas to Experience a Decrease

By Dawn Rowe, CPA, MBA, CPC

In the August 11, 2009 Federal Register, CMS issued new Medicare rates effective for Federal Fiscal Year (FFY) 2010 beginning 10/1/09. Although the market basket update applied to the payment rates is a positive 2.2%, CMS implemented its proposal to “recalibrate” the case mix indices contained in the current RUG-53 model, the impact of which lowers total payments to SNFs by approximately \$1 billion or a negative 3.3%. The combined impact of the market basket update and recalibration is a negative 1.1% update of \$360 million for the new rates.

RUG Recalibration Due to Changes in Utilization

According to CMS, the recalibration is necessary to account for changes in actual utilization patterns between the original 44 RUG groups to the current 53 group model. The adjustment that occurred in January 2006 when RUG-53 was implemented was supposed to ensure that payments under the revised 53 RUGs were the same as they would have been using the 44 RUG categories. However, the adjustment actually resulted in a significant increase in overall payments resulting in “substantial overpayments to SNFs.” Although it seems that the timing of this correction couldn’t be worse given the current economic climate, CMS felt it was important to implement the recalibration now, prior to the implementation of the new RUG-IV model scheduled to be implemented next year (FFY 2011).

Actual Payment Impact Varies by RUG Category and Wage Area

Unlike previous updates which were driven solely by the market basket update, the actual impact on payments will be different for each facility, depending on the mix of patients they serve. This is because the recalibration affected the case mix indices for each RUG category specifically. Payments also vary by

region due to differences in the area wage index which continues to be based on hospital cost report data. The wage index for FFY 2010 will be applied to 69.84% of the payment rate, which is down from the current 70.249%. A comparison of the wage indices by core based statistical area is shown in the chart on the next page.

Therefore, the impact of the decrease in payments will be less in the Baltimore area, for example, than in the Bethesda/Frederick area due to the change in the wage index between years. For the rates for your region, please refer to the newsletter link on our website at www.schiavi-wallace.com.

More Changes Ahead: RUG-IV and MDS 3.0

CMS is finalizing the RUG-IV model for implementation in FFY 2011. The RUG –IV update is based on information collected in the 2005 Staff Time and Resource Intensity Verification (STRIVE), which CMS believes “reflects current medical practice and resource use in SNFs across the country.” STRIVE was a study conducted in a sample of facilities that collected information on the amount of time staff members spend on residents, and included information on clinical data based on the MDS. The RUG-IV model contains 66 payment rates, and will coincide with use of the new MDS 3.0 patient assessment tool. CMS will again attempt to make overall payments equal with those under the current 53 group model. CMS included a projected impact on payments under RUG-IV, assuming no

Also In This Issue:

- ◆ *Medicaid Cuts Rates Again, Effective 8/1/09*
- ◆ *PS&R Redesign Means Big Changes for Medicare Cost Report Filing*

WAGE INDICES COMPARISON			
MSA	2010 Wage Index	2009 Wage Index	Difference Wage Index
Baltimore	1.0214	1.0055	0.0159
Washington	1.0882	1.0827	0.0055
Wilmington	1.0555	1.0696	-0.0141
Hagerstown	0.8965	0.8997	-0.0032
Cumberland	0.8045	0.7816	0.0229
Rural	0.9131	0.8883	0.0248
Bethesda/ Frederick	1.0298	1.0548	-0.0250
Salisbury	0.9110	0.9246	-0.0136

change in overall payments. As with the current RUG recalibration, they estimate that some facilities will experience payment increases and some will experience payment decreases based on their individual Medicare utilization.

In addition to the increased number of RUG categories, CMS will change the way concurrent therapy minutes are reported on the MDS. Concurrent therapy will be required to be allocated among the patients receiving it prior to reporting total therapy minutes on the MDS. In addition, therapists will be required to report therapy between the three different modes (individual, concurrent and group) on the MDS. Furthermore, CMS will eliminate the look-back to the hospital stay for certain services as STRIVE found that it does not provide an effective proxy for medical complexity for SNF residents.

The MDS 3.0 is expected to require greater resident involvement, and include survey items that are more clinically based. There will be changes in the assessment schedule as well as in transmission and will require staff training to ensure the accuracy of the data.

Expect more challenges ahead!

The Pain Never Ends

Medicaid Cuts Rates Again

Effective August 1, 2009

By: Judy Schiavi, CPA, MBA

By now you will have received your August 1, 2009 rate letter that indicates the “across the board” cut has been increased from 4.816% to 8.681%--a cut that is impacting providers by anywhere from \$3.32 to \$5.46 per patient day.

This cut has caused a much more painful impact due to it coming so soon after the Nov 1, 2008 reduction and the July 1, 2009 non-existent rate increase. Unfortunately, we are not hearing anyone promise that this will be the last of the cuts. Until the national economy improves, Maryland’s budget problems are fated to continue.

State and industry representatives are meeting later this month to determine whether there is any more palatable way to make the cut than having an across the board reduction. But no matter what ideas are presented at that meeting, the cuts have moved past painful into downright scary.

So what is a provider to do? The only choice you have is to move into survival mode. We talked about some of the more obvious ways to save money in our February newsletter (for a copy, go to www.schiavi-wallace.com, “newsletters” and download). These ideas included minimizing bad debts, reviewing therapy and pharmacy contracts, looking at private pay rates and revenue capture among others.

Assuming that you’ve looked at all of those ideas, now it’s time to take things a step further.

1. Budgeting has never been more important
 - Medicare rates effective 10/1/09 are now available (refer to the previous article). If your original budget didn’t take into account the reduction in Medicaid revenue and the Medicare “corrections”, NOW would be a good time to revise it!

1. Budgeting, cont'd

- Make sure that you and your staff are looking at the “right” numbers when you look at your budget. Your expense budget probably provides for a monthly goal by dollar and PPD for each line. If you have a 120 bed facility, and the budget was based on 110 beds due to a moment of optimism-- but in actuality you are only running at 105-- you need to be multiplying the 105 by the PPD and shooting for the resulting lower number, not the dollar amount that was based on the 110 beds.

2. Take a hard look at your payroll costs

- Are there any positions that you could reduce from 8 hours per day to 7 ½ hours a day? We have had a couple of our clients implement this change in the business office which resulted in significant annual savings.
- Are you really monitoring overtime as closely as you could? Employees who repeatedly punch in 15 minutes early and/or punch out up to 30 minutes late can add a tremendous increase to your payroll costs with no benefit to the facility. Employees become used to this extra money so be ready to enforce your policies.
- Have you priced out the difference between agency costs and in house nurses by position? Once you factor in benefits and overtime, agency can be surprisingly cheaper in some positions.
- Have you looked at your staffing mix? Are there circumstances where you could provide coverage by using more medicine aides and fewer licensed nurses?

- Does your staffing coordinator develop a call list that gives priority to the lower cost options (ie: taking into account who has already worked 40 hours and would therefore be receiving overtime pay vs. regular pay if called in or agency if that is cheaper for that position?).
- Do you have any positions, such as the receptionist, that could be staffed by volunteers or even shared by other employees on a rotating basis?
- Do you have any positions that could be combined, such as Quality Assurance and the ADON, or Training?

3. Re examine all vendor contracts

- When is the last time you priced your supply vendors, including nursing, housekeeping and office supplies? Have you taken advantage of all group purchasing options available through your associations? Sometimes when you've had a contract in place over a long period of time, the costs increase out of proportion to what is really going on in the outside market. We are finding that now, in particular, is a good time to lock in lower rates as companies are trying to be more competitive.
- Look at and use the additional services your vendors are offering. Has your laundry service looked at your machines to make sure they are calibrated for the type of chemicals used? If not, you could be using more supplies than you need to.
- Have you met with your pharmacy representatives to talk about better processes to avoid pre-authorization problems? Are the communications between your pharmacy and the business office regarding pendings effective?

4. Continually monitor waste within the building
 - Do you have lock boxes on the thermostats? We've had clients find the heat being put on in the evening, the air during the day, with neither being shut down properly.
 - Is laundry only done with full loads?
 - Could purchasing or renting a trash compactor allow you to have less frequent trash pick-up?
5. Monitor revenues and census closely
 - Pay attention to how fast you fill a bed. Delays of even one or two days on an admission can cost you revenues that you cannot afford to lose. This is particularly true in assisted living and independent living units that have to be refreshed before someone else moves in.
 - Has census dropped to a level where you might want to consider a voluntary or temporary bed reduction?
 - Review revenue capture procedures. Do your patient assessment adjustments reveal a documentation problem? When you have them, are your unbilled but verified billings being sent in timely? Are you properly documenting administrative days?

And finally, make sure you bring your staff into these discussions on a daily basis. They are in a better position to see how things could be done more efficiently. If you don't already, consider implementing an award program for employees who offer suggestions that save the facility money.

Do you have some unusual cost cutting ideas? Share your thoughts with us and we'll pass them along! Email me at jschiavi@schiaiv-wallace.com. Thanks to Brant Hart at Pickersgill and Sandi Mennerick at College View for sharing many of the above ideas with us.

PS&R Redesign Means Big Changes for Medicare Cost Report Filing

By Dawn Rowe, CPA, MBA, CPC

Effective for cost reports ending on or after January 1, 2009, Medicare providers will have to go online via the CMS IACS system to retrieve the PS&R information necessary to file their cost reports. ***Hard copy summary PS&Rs will no longer be distributed by the Medicare Administrative Contractors (MACs) or Fiscal Intermediaries (FIs).*** Many of you have already received correspondence from your MAC or FI requesting you to register on this new online system. If you haven't already done so, you should register and establish the appropriate system users as soon as directed to make sure you are able to file your cost report by the deadline. CMS has issued three MLN Matters articles on the IACS system as well as a Frequently Asked Questions document specific to the PS&R redesign to assist providers in this process. It is highly recommended that you download the FAQs document that contains links to the MLN Matters articles and IACS user guide. Refer to the CMS website, and specifically <http://www.cms.hhs.gov/PSRR/> for further guidance. Below are some Q&As to assist in the process:

What is IACS?

IACS stands for Individuals Authorized to Access CMS Computer Services. It will be a gateway to many CMS systems, including the PS&R system.

When do I need to register in IACS?

Providers will receive notice from their MAC/FI advising them when to register. Providers should not register before receiving notice to do so.

Who must register in IACS?

The first person to register in IACS is the Security Official (SO), and the SO is responsible for registering the organization. **It is important to note that the SO cannot be the person responsible for retrieving the PS&R information off the system; there must be at least two persons at a provider registered in the IACS system:** an SO, and at least one other user to provide for a segregation of duties.

What does the SO need to register the organization in IACS? What are the steps in the registration process?

First, the SO needs to be established. Prior to going on line to register, the SO is required to have:

- The Tax Identification Number (TIN)
- Legal Business Name
- A hard copy of the IRS Issued CP 575 or other official IRS documentation on IRS letterhead that contains the printed legal business name and TIN.

Once the initial online registration information is completed by the SO, the hard copy IRS documentation gets mailed into CMS. It can take several weeks for CMS to verify the SO’s role in the organization, as well as the TIN and legal business name. Once the SO is approved by CMS through its EVS help desk, the SO has the ability to go online and establish other users.

Who are the other users of the system?

An organization can elect to have a back-up SO who can do everything a SO can do except approve another back-up or update the organization’s profile. Other user types include a User Group Administrator or UGA who approves the requests of End Users of his group and the End User who is part of a user group and is the person responsible for performing Medicare business and conducting transactions for a provider.

Can a home office register in the system?

Officially, reports can only be generated through participating providers. However, individuals who work for more than one provider or serve in multiple roles in the same organization can add additional roles to their account (although they should have only one account and should register only once). Therefore, home office employees can also be designated as end users of particular providers. More than one user at a provider can request access to the PS&R through IACS.

What are the reports that I need to get off the system?

The reports needed for the cost report are found in the PS&R/Cost Report crosswalk section. For cost report filing purposes, providers should request all reports.

When should I access the PS&R reports from the system?

Although, CMS suggests you allow some time after your fiscal year end before running a PS&R so that there is time for claims processed after year end, but for dates of service prior to year end to be included, you should also attempt to run your PS&Rs far enough before the cost report deadline to allow for problems. If you are unable to run the reports, or have questions about them, CMS advises that you contact your MAC/FI at least 45 days prior to the cost report due date. Since there is no limit on the amount of summary PS&Rs that you can request from system, we recommend that you attempt a trial run well before the cost report deadline, and then run the “final” PS&R to be used for cost report purposes approximately 50 days prior to the due date.

What format should I request the PS&R in?

The PS&R is available in both a PDF (read only) and CSV format. The CSV format can be downloaded to spreadsheet software, such as excel, and therefore may provide more flexibility to the cost report preparer.

It should be noted that unlike the old or “legacy” PS&Rs, system generated PS&Rs will not contain data prior to implementation of the new system. In addition, all requests for detail PS&Rs (not the summary PS&Rs used for cost reporting) should still go to the MAC/FI. Providers are allowed only one detailed PS&R per year for free.

Don’t delay registering your organization in the IACS system, establishing the system users and practicing accessing the PS&R information. If you do, you could face filing your cost report late, which can result in reductions and suspensions of your Medicare payments.

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 and after a thorough examination of the facts of the particular situation.

Schiavi, Wallace & Rowe is proud to be a sponsor of
the Double Feature Conference:
HFAM / LIFESPAN Network in Ocean City

Please join us for Sue Littlejohn's session on September 29th entitled

***“The Business Office:
Are Your Numbers Snowballing Into a Blizzard?”***

This session will assist the Administrator in identifying key elements of business office operations to monitor in order to prevent costly delays and meet regulatory requirements. Particular areas of discussion will include accounts receivable aging reviews, Medicaid and Medicare billing, and resident fund management.

See you in September!

