Maryland Medicaid Rates Increase by 1.72%
By Judith M. Schiavi, CPA, MBA

Effective July 1, Maryland skilled nursing facilities can expect to see Medicaid interim rate increases averaging 1.72%. The State had originally budgeted for a 1.5% increase (at a total cost of $19.8 million). However, an additional $3 million was approved in the supplemental budget specifically to help nursing homes deal with the lost dollars from the phase out of allowable bad debt reimbursement in the Medicare program.

So how much money will this mean to my facility?
The Statewide average in Rate Year 2013 was $235.35. So a 1.72% increase will mean approximately $4.06 in additional reimbursement for each Medicaid day of service.

How will my rates be affected by changes to Quality Assessment (Provider Tax)?
Maryland’s quality assessment tax is already at the federal maximum of 6% of net revenues of participating facilities. So the FY 2013 provider tax rate of $22.94 was based upon projected net revenues of more than $2.3 billion for Maryland facilities. The State computed this value by taking actual revenues from the 2011 cost reports and applying an estimated inflation factor of 1.5% (for 2012) and 1% (for 2013) to restate those revenues in rate year 2013 terms. Now that the 2012 cost report data has been received by Myers and Stauffer, the State will be able to update these projections which will likely result in a small increase to the tax rates. And when the tax rates change, the resulting portion of provider interim rates related to quality assessment will also change. So if the provider tax increases by 3 to 5%, you would see an increase to the capital component of your Medicaid rate in proportion to your Medicaid mix. For example, if the tax rate increases by $.65 cents per patient day, and you are 10% Medicare and 60% Medicaid, you would see an interim rate increase from the change in provider tax of about $.43 per patient day—in addition to the average of $4.06 above.

The Issue of Rebasing
The industry was fully funded for a brief period of time back in Rate Year 2009, then the national economic crisis caused the State to begin making various budget cuts in the form of changes to the system (for example: cycling down incentive parameters, removal of bed hold days, removal of CDC additional procedure payments), and also applying “across the board” cuts to our rates.

In fact, you may not realize this, but each year since that time, the State has set interim rates WITHOUT any comparison to actual costs submitted or the cost report. Your interim rates that your facility is receiving right now are based upon your 2007 cost report—unless you have applied for and received an interim rate adjustment.

The reason for this is simple—there hasn’t been enough money in the budget to fund the system the way it was designed. If the State were to “rebase” our interim rates by using costs from the 2012 cost reports and calculated new ceilings and parameters the way it was done prior to Rate Year 2009, they would be back in the same position of having to reduce rates in some way. State estimates show that a full rebasing

Also in this issue:
- Proposed Medicare Rate Update
- Medicaid Goes PPS 7/1/14
Maryland Medicaid Rates Increase (continued)

would cause many facilities to experience a large swing (positive or negative) in their interim rates.

The State also recognized that the planned implementation of a new prospective payment system for Maryland Medicaid (projected implementation date July 1, 2014) could also cause material swings in the payment rates of some facilities. Therefore in the interest of payment stability, it was decided that no rebasing should occur, and each year the interim rates, based on those 2007 cost reports, have been just adjusted to account for the change in the overall Medicaid budget.

**Potential Impacts of Not Rebasin**

How does the fact that the State hasn’t rebased since Rate Year 2009 affect your facility? It may be time for a rate adjustment. Consult with your accountant to determine whether your current costs meet the guidelines for requesting a rate change (must be a 2% increase in nursing and a 10% increase in all other cost centers in order to receive permission to increase your rates).

Even if your cost changes do not justify a rate change, make sure that you are calculating and booking anticipated future cost report settlements. The number of years since rebasing makes it more likely that these settlement amounts could be material.

**How can I calculate my new rate before the rate letters come out?**

The formula for nursing reimbursement is complicated enough without adding in any additional factors. Therefore, State officials decided that rather than adding 1.72% to all cost centers including nursing, it would be easier to implement an increase to only Other Patient Care, Routine and Admin, and Capital. To provide the industry with the same total dollars as a 1.72% increase to the total rate, these cost centers will be increased by 3.2%.

Take your FY 2013 interim rate letter dated July 6, 2012 and follow along with this calculation.

<table>
<thead>
<tr>
<th>Cost Center</th>
<th>Example</th>
<th>Your Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin and Routine</td>
<td>Interim Payments</td>
<td>$ 63.21</td>
</tr>
<tr>
<td>Other Patient Care</td>
<td>Interim Payments</td>
<td>13.13</td>
</tr>
<tr>
<td>Capital Cost Center</td>
<td>Interim Payments</td>
<td>35.36</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$111.70</strong></td>
<td><strong>3.20%</strong></td>
</tr>
<tr>
<td><strong>Increase in Interim Rate</strong></td>
<td><strong>$3.57</strong></td>
<td><strong>3.20%</strong></td>
</tr>
</tbody>
</table>

While your facility’s actual July 1 interim rate may vary slightly from this calculation depending upon the final change in the provider tax rate, this will give you an idea of your expected rate increase.

The good news about this increase is that unlike a change to a specific ceiling or other individual cost center parameter, these funds can be spent in any cost center.

**How can I learn more about my facility reimbursement?**

Want to learn more? Schiavi, Wallace & Rowe will be sponsoring a reimbursement seminar with HFAM on July 16th in Turf Valley. See the back page of this newsletter for the range of topics that will be discussed.

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**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.
Proposed Medicare Rate Update

It’s time to do something about the Wage Index

By Dawn L. Rowe, CPA, MBA, CPC

The Centers for Medicare & Medicaid Services (CMS) issued their proposed rule for SNF Medicare payments effective October 1, 2013. Published in the Federal Register on May 6, 2013, CMS projects an overall increase of 1.4% in SNF payments, but no Maryland SNF will receive this increase due to the impact of the area wage index. In fact, some Maryland areas, including the Baltimore core based statistical area (CBSA), will see a rate decrease based on the data in the proposed rule.

The 1.4% proposed update is based on the following components:

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket Update</td>
<td>2.3%</td>
</tr>
<tr>
<td>Forecast Adjustment Error</td>
<td>(.5%)</td>
</tr>
<tr>
<td>Multi-Factor Productivity Adjust</td>
<td>(.4%)</td>
</tr>
<tr>
<td>Proposed Payment Update</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

The area wage index is applied to approximately 70% of the federal RUG rates, therefore the actual proposed payment updates per Maryland CBSA are as follows:

<table>
<thead>
<tr>
<th>CBSA</th>
<th>Projected FY 14 Rate Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>(.17%)</td>
</tr>
<tr>
<td>Washington</td>
<td>.92%</td>
</tr>
<tr>
<td>Bethesda/Frederick/Gaithersburg</td>
<td>1.3%</td>
</tr>
<tr>
<td>Hagerstown</td>
<td>.25%</td>
</tr>
<tr>
<td>Cumberland</td>
<td>(4.5%)</td>
</tr>
<tr>
<td>Salisbury</td>
<td>(.72%)</td>
</tr>
<tr>
<td>Wilmington Metro</td>
<td>1.15%</td>
</tr>
<tr>
<td>Rural</td>
<td>.76%</td>
</tr>
</tbody>
</table>

Note that the above does not take into account the (2%) sequestration adjustment currently in effect.

A Brief Review of the Wage Index

Since the beginning of SNF PPS, CMS has been adjusting a large portion of the Federal RUG rates to account for differences in area wages. The wage index is based on wage data as reported in Medicare Cost Reports by hospitals nationwide, and is grouped into areas based on the US census data (formerly MSAs, now CBSAs). Each area’s aggregated wage data is compared against a national average. If an area’s wage data is above the national average the area wage index will be above a 1.0, if it is below the national average it will be below a 1.0. Therefore, hospitals in your CBSA directly impact the wage index that is applied to your SNF PPS rates.

Although SNFs also report wage data in their Medicare Cost Reports (refer to Worksheet S-3 Part II), CMS has deemed it unreliable since it has never been subject to audit. They also feel the development of a SNF specific wage index would require too much effort. Since Medicare’s PPS for acute care hospitals has been in effect since the early 1980s and the hospital wage data has been audited for years, CMS states that it is “reasonable and appropriate” to use for the SNF PPS.

The Maryland Hospital Problem

Unfortunately for Maryland SNFs, it may not be reasonable and appropriate to apply the hospital wage index to their rates. Unlike the rest of the country, Maryland’s hospitals have a waiver from Medicare’s inpatient acute care prospective payment system (IPPS). This means the wage data reported on their hospital cost reports is little more than a compliance requirement for them; it does not affect their payment rates because they are not paid under the IPPS. Hospitals outside of Maryland, however, have a strong incentive to optimize their wage data reported on their cost reports as the wage index is also applied to large portion of their rates. In fact, there are national consulting firms with practices dedicated solely to wage index optimization.

A comparison of the current wage indices for Maryland CBSAs to the proposed wage indices (based on
wage data from hospital Cost Reports beginning between 10/1/09 and 9/30/10, or mostly 6/30/11 reports for Maryland hospitals) shows the following unfavorable trend:

<table>
<thead>
<tr>
<th>CBSA</th>
<th>Proposed Wage Index</th>
<th>Current Wage Index</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baltimore</td>
<td>.9916</td>
<td>1.0147</td>
<td>(.0231)</td>
</tr>
<tr>
<td>Washington</td>
<td>1.0570</td>
<td>1.0659</td>
<td>(.0089)</td>
</tr>
<tr>
<td>Bethesda/Frederick/Gaithersburg</td>
<td>1.0348</td>
<td>1.0374</td>
<td>(.0026)</td>
</tr>
<tr>
<td>Hagerstown</td>
<td>.9273</td>
<td>.9422</td>
<td>(.0149)</td>
</tr>
<tr>
<td>Cumberland</td>
<td>.8088</td>
<td>.8836</td>
<td>(.0748)</td>
</tr>
<tr>
<td>Salisbury</td>
<td>.8986</td>
<td>.9260</td>
<td>(.0274)</td>
</tr>
<tr>
<td>Rural</td>
<td>.8733</td>
<td>.8997</td>
<td>(.0064)</td>
</tr>
</tbody>
</table>

Every Maryland CBSA shows a decrease, and keep in mind that a wage index below 1.0 means the area is below the national average hourly wage rate. The national average hourly wage rate per the Hospital IPPS proposed rule is $38.2384. It doesn’t seem reasonable that wages in the Baltimore area would be below the national average and 6.5% below neighboring Washington, DC. Washington, however, has 20 non-Maryland hospitals reporting wage data in their CBSA out of 27 total hospitals. Cumberland has only one hospital in the entire CBSA.

So, what can be done about the Maryland wage index issue?

Unfortunately, the wage index is not the only way that SNFs are harmed by the Maryland hospital waiver. SNFs also pay higher rates for ancillary services provided by Maryland hospitals that are included in consolidated billing. Outside of Maryland SNFs can pay hospitals the Medicare fee schedule rates for these same services versus the higher Maryland regulated rates. Since Maryland hospitals are prohibited from negotiating their rates with payors, SNFs are charged regulated rates and the only relief is that they are afforded the Medicare allowed discount (between 4-6%).

Over the years CMS has been approached by Maryland SNFs regarding these issues, with no progress to date. SNFs in the Bethesda CBSA formed a group appeal on the wage index issue several years ago, only to be advised by attorneys that their chance for success was less than 30%. The appeal was subsequently dropped.

CMS is well aware of the pitfalls within the existing wage index, that it is subject to large swings in year to year data (i.e. Cumberland), and that there is a cottage industry of consulting firms dedicated to wage index maximization. As a result, and per mandate under the Affordable Care Act, CMS has been studying ways to implement wage index reform. However, it’s most recent report to Congress on wage index reform in April 2012 focused on developing a commuting-based wage index (CBWI) by using commuting data to define hospital labor markets. This could require more information to be reported by hospitals to CMS including employee counts by geographic area of residence. This would not appear to solve the Maryland problem. Previous studies covered scrapping hospital reported wage data all together and moving towards other publicly available data such as that published by the Bureau of Labor Statistics.

In order to achieve reform, Maryland SNFs may need to address the issue collectively and through their associations, as smaller groups of Maryland SNFs have been unsuccessful in the past.

Other Provisions in the Proposed Rule

While the wage index was the biggest driver for rates in Maryland, a few other provisions are worth noting.

Rebasing & Revising the SNF Market Basket: CMS is proposing to revise and rebase the SNF market basket to FY 2010 data. Currently the data is based on FY 2004. CMS notes that “rebasing” means shifting the base year that the costs used to construct the market basket came from. They are proposing to rebase to use Medicare allowable costs from SNFs 2010 cost reports, the most recent year from which complete data is available.
CMS notes that “revising” means changing data sources, cost categories, and/or the actual methodology used in developing the index. These categories can include things like salaries, benefits, contract labor, and professional liability insurance. The current market basket uses 23 categories, and the proposed would use 29 categories. Note again that many of these categories come from SNF Medicare Cost Reports (including contract labor as reported on S-3 Part II). Therefore, the accurate preparation of your Medicare Cost Report continues to play a factor in how your SNF Medicare rates are developed.

This change is important because if there were to be no revision or rebasing and the SNF market basket was based on the current 2004 data, the market basket before other adjustments would be 2.5%, not the 2.3% as currently proposed. In fact in all comparisons made by CMS of the current 2004 based market basket to the proposed 2010 based market basket the 2010 data results in a lower index.

**Addition of data field to MDS:** CMS is proposing to add “distinct days of therapy” to the MDS Item Set. This is to capture the number of distinct days of therapy provided in the seven day look-back period, and could affect patients currently qualifying to a medium rehab RUG category. Patients should be receiving five days of any combination of rehabilitation disciplines to classify to the medium category. Without the “distinct days of therapy” field in the MDS they could be currently grouping to a medium Rehab RUG just by receiving five disciplines that are not necessarily provided on five distinct days.

**Potential Changes to CBSAs:** The wage index could be further impacted in the future if CMS chooses to adopt revisions to Metropolitan Statistical Areas as a result of the 2010 census. You may recall that previous revisions based on the 2000 census included the establishment of additional Maryland CBSAs for facilities formerly included in the Washington, DC MSA (Bethesda), and those formerly included in Rural (Cumberland and Salisbury). Further changes to MSAs could be implemented, but CMS notes that they need to study the effect and plans to do so for Fiscal 2015.

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**Deadline for Responses to the Proposed Rule**

Comments must be received by CMS no later than 5 p.m. on July 1, 2013. We encourage Maryland SNFs to consider commenting on CMS’s plans to continue using the hospital wage index for SNFs, as well as the implication of rebasing and revising the market basket. To read the proposed rule in detail refer to:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html

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**Maryland’s New Prospective Payment System**

**LOOMING AHEAD**

Judith M. Schiavi, CPA, MBA

*Is your facility ready?*

There are still plenty of “unknowns” about this change in the Medicaid program, but here is what we know for sure:

- The State intends to convert to a PPS (prospective based system) 7/1/14
- Providers will still be required to file annual cost reports, however there will be no retrospective final settlement
- The State intends for the new PPS system to be budget neutral, meaning that the total dollars in the system now will be the total dollars in the new system
- There will be “winners” and “losers” in the conversion from the current system to the new PPS system
- There will be some type of “phase in” from the old system to the new system to allow providers time to adjust to the change in rates
- Nursing and Other Patient Care will be combined and will be paid using RUGS scores, rather than levels of care
- The new system will still provide incentives for efficiency
- The new system may be a price based system
- The capital component may be a fair value system, rather than the current net capital value system

What do all these things mean? Attend the SWR seminar on July 16th (see back page for details), so that you can plan now for the changes to come. If you have further questions, contact me at jschiavi@schiavi-wallace.com.
THE FUN NEVER ENDS!
PLEASE JOIN US FOR OUR
ANNUAL REIMBURSEMENT UPDATE

July 16th - 9:30 to 4:00

In addition to an in-depth discussion of Maryland’s new PPS System with Joe Lubarsky

Topics will include:

✓ The Affordable Care Act
✓ Consolidated Billing & Bad Debts Refreshers
✓ Policy Update with Susan Panek
✓ Rebalancing Initiative

To be held at

Wedgewood Room
Turf Valley Conference Center
2700 Turf Valley Road,
Ellicott City, MD, 21042,

For additional information and to register, check out the events calendar at

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