Medicaid Nursing Facility Rate Reform

Implementation beginning January 1, 2015

Presentation by:
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What changes on January 1, 2015?

- Revenue code changes for dates of service on and after January 1, 2015.
- Maryland Monthly Assessment is no longer required for dates of service on and after January 1, 2015.
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- Days of service will be paid in full at the time of claim (no cost settlement).
- Everything else – business as usual.
Assistance Along the Way

• Please refer to the following manuals for instructions on the new process:
  – Uniform Billing (UB04) Nursing Facility Billing Instructions
  – Nursing Facility Reimbursement Manual

• Information and forms are available on our website:
New system has 11 revenue codes

- Facility-specific rates will be mailed at the beginning of each quarter (see appendix 1 of Reimbursement manual).
- One Resident Care Day rate replaces the previous acuity system (light, moderate, heavy, heavy special).
- Ventilator residents are billed separately from the Resident Care Day rate.
- Certain nursing and therapy add-ons were consolidated into the Resident Care Day rate; others specifically listed in the reimbursement manual should be claimed separately.
- All billing is done using the Uniform Bill for institutional providers (UB04).
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<th>HIPAA Compliant Revenue Code Description</th>
<th>Revenue Code</th>
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<td><strong>DAILY RATES</strong></td>
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<tr>
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<td>Rm &amp; Brd Semi-Private - Other</td>
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<td><strong>OTHER COSTS (BILLED IN ADDITION TO DAILY RATES)</strong></td>
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<tr>
<td>Class A Support Surface</td>
<td>DME – General</td>
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<td>Class B Support Surface</td>
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<tr>
<td>Bariatric Bed A</td>
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<td>0946</td>
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<tr>
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<td>Power Wheel Chairs</td>
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</tbody>
</table>
Resident Care Day (0120)

• For each day of direct service, with the exception of a resident on a ventilator, bill this code.

• Previously, additional add-ons were billable. Under the RUGs-based methodology for paying nursing services, many of these add-ons are now included in the Resident Care Day rate for each facility and may not be billed separately.

• Ventilator residents are billed separately (see next slide).

• See page 7 of the reimbursement manual.
Ventilator Resident Care Day (0129)

• The facility must be approved by OHCQ to provide ventilator services. Claims will not pay if the facility is not approved.

• Ventilator Resident Care Day rate is inclusive of a Resident Care Day rate and additional costs associated with ventilator care.
  – Ventilator rate and other daily rates cannot be billed on the same day.

• Records must be kept to validate the claim.

• See page 7 of the reimbursement manual.
Administrative Day (0169)

• May be billed if the resident no longer qualifies for nursing facility level of care.
• No changes from the previous process.
• The DHMH 2129 must be completed.
• See page 7 of the reimbursement manual.
Therapeutic Bed Hold Day – Leave of Absence (0183)

• Payments for the cost of reserving beds for recipients for therapeutic home visits or participation in State-approved therapeutic or rehabilitative programs.

• No changes from the previous process.

• See page 8 of the reimbursement manual.
Coinsurance Day (0101)

- Billable for residents in both Medicare Part A and Medicaid.
- No changes from the previous process.
- See page 8 of the reimbursement manual.
Support Surface – A (0290)
Support Surface – B (0299)

• No changes from the previous process.
• These codes are billed in conjunction with a daily rate (i.e., 0120, 0129 and 0169).
• See page 9-11 of the reimbursement manual.
• Information on Decubitus Ulcer Care available in Appendix 3 of the reimbursement manual.
Bariatric Bed – A (0946)
Bariatric Bed – B (0921)

• No changes from the previous process.
• These codes are billed in conjunction with a daily rate (i.e., 0120, 0129 and 0169).
• See page 11-12 of the reimbursement manual.
Negative Pressure Wound Therapy (0270)

• Claims only for supplies associated with therapy. Nursing time is included in the Resident Care Day rate.

• This code is billed in conjunction with a daily rate.

• No additional changes to the current process.

• See page 12-14 of the reimbursement manual.
Power Wheel Chairs (0947)

• Preauthorization form must be submitted and approved by the Department. (See appendix 4 of the reimbursement manual.)
• You must receive a letter with instructions and a billable amount prior to submitting a claim.
• Payment is made in full through the above revenue code.
• See page 14 of the reimbursement manual.
Billing for Services

• UB04 instructions outline required fields for billing.
• Submitting invoices and adjustments process are the same.
• Facility must check Medicaid eligibility (EVS).
• Claims must be submitted within 12 months from the date of service.
Facility Responsibilities

• Submit accurate MDS data.
• Maintain a secure email on file with the Department (to receive resident rosters and rate letters).
• Review resident rosters quarterly.
• Maintain resident records.
Resident Roster Review

• Delivered electronically through secure email.
• Rosters are delivered on the 5th day of the second month after the
  quarter has ended. Revisions are due by the 25th of that month.
  – For example, for quarter ending March 31, rosters will be distributed on May
    5th. Revisions are due May 25th.
• Resident Roster Correction Process Manual and calendar available online.
• Case mix from the reviewed roster will be used to set the next quarter’s
  rate.

<table>
<thead>
<tr>
<th>Resident Roster Quarter</th>
<th>Rate Quarter</th>
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<tbody>
<tr>
<td>January – March</td>
<td>July – September</td>
</tr>
<tr>
<td>April – June</td>
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Getting to a Resident Care Day Rate

- Calendar year 2012 settled cost reports were used to calculate each facility’s current rate.
  - Incorporated all four cost centers, certain add-ons and cost settlement adjustments.
- Used the new model to determine a rate under the new methodology.
- Blended the two rates together to get a phase-in rate.
  - Phase-in planned over 18 months.
  - Facilities should adjust as necessary to new payment system.
- The first phase, effective January 1, 2015, is based on 75 percent of the current methodology and 25 percent of the rate under the new methodology.
New Methodology – Nursing Cost Center

• Nursing Cost Center
  – Five regional prices
    • Median + 8.25%.
  – Regional price is case mix adjusted to determine a facility-specific rate.
  – If a facility’s projected cost is less than 95 percent of the rate, then the rate is reduced by the difference.
  – Case mix is determined from MDS data sorted into RUG-IV 48-group classification system.

• Ventilator Add-on
  – One consolidated payment for each day of service.
  – Carving out ventilator RUGs from the Resident Care Day rate, assigning a value and adding $280 per day.
New Methodology – Administrative and Routine Costs and Other Patient Care

• Price-based system using cost report data by region.
  – Admin and Routine = Median + 2.5%
  – Other Patient Care = Median + 7.0%

• Unless rebased, the Department will adjust the price annually based on Skilled Nursing Facility market basket inflation index.

• Re-base using cost report data to align with regional costs every two to four years.
New Methodology – Capital Cost Center

• Fair Rental Value + real estate tax pass through.
• Appraisal value per bed maximum set at $110,000 with no minimum.
• Two rental factor percentages:
  • Baltimore City
  • All other jurisdictions
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Visit our website for manuals and forms:


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